						2/23/201/ 4	1:28 bw
PART I - COST	REPORT STATUS						
Provi der	1. [ X ] Electron	nically filed	cost report		Date: 2/23	3/2017 Ti me:	4: 58 p
use only	2. [ ] Manual I y	y submitted co	ost report				
			l report enter the number Enter "F" for full or "		r resubmitted thi	s cost report	
Contractor use only	(1) Ås Submit	ted vithout Audit	6. Date Received: 7. Contractor No. 8. [ N ] Initial Report f 9. [ N ] Final Report for	for this Provider CCN 1			

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DEKALB MEMORIAL HOSPITAL (15-0045) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
T: +1 o	
Ti tl e	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-51, 883	87, 423	0	-124, 707	1.00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9. 00
200.00	Total	0	-51, 883	87, 422	0	-124, 707	200. 00

Date

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			In-State	In-State	Out-or	Out-or	wear car a	other	
unpaid days eligible unpaid  1.00 2.00 3.00 4.00 5.00  24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 6.			Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
days unpaid 1.00 2.00 3.00 4.00 5.00 6.00  24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 6.			paid days	eligible	Medi cai d	Medi cai d		days	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 6.			,	unpai d	paid days	eligible			
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.				days		unpai d			
in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	24.00	If this provider is an IPPS hospital, enter the	267	482	0	11	844	0	24. 00
out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		in-state Medicaid paid days in column 1, in-state							
out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		Medicaid eligible unpaid days in column 2,							
4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		out-of-state Medicaid paid days in column 3,							
column 5, and other Medicaid days in column 6.		out-of-state Medicaid eligible unpaid days in column							
column 5, and other Medicaid days in column 6.		4. Medicaid HMO paid and eligible but unpaid days in							
25. UU ILT THIS PROVIDER IS AN IRE, ENTER THE IN-STATE I UI I 25. (	25. 00	If this provider is an IRF, enter the in-state	0	l o	l о	l o	l o		25. 00
Medicaid paid days in column 1, the in-state		·							
Medicaid eligible unpaid days in column 2,		1 3							
out-of-state Medicaid days in column 3, out-of-state									
Medicaid eligible unpaid days in column 4, Medicaid									
HMO paid and eligible but unpaid days in column 5.									
hame been and an extension and an extension of the state			1	1	1	1	1	1	

Health Financial Systems			AL HOSPITAL			u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DA	TA	Provi der CC		eriod: rom 10/01/2015 o 09/30/2016	Worksheet S-2 Part I Date/Time Pre 2/23/2017 4:5	pared:
		Y/N	IME	Direct GME	I ME	Direct GME	D pin
61.06 Enter the amount of ACA §5503 awa used for cap relief and/or FTEs t care or general surgery. (see ins	hat are nonprimary	1.00	2.00	3.00	4.00	5. 00	61. 06
		Program Name Program Code L  1.00 2.00 3.00  Program Name Program Code L  1.00 2.00  1.00 2.00  Tam  ts  n  he  ME  d Services Administration (HRSA)  ital trained in this cost reporting period structions)  rom a Teaching Health Center (THC) into y program. (see instructions)  ovider Settings er settings during this cost reporting period omplete lines 64-67. (see instructions)  Unweighted FTES		Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
61.10 Of the FTEs in line 61.05, specific specialty, if any, and the number for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in column FTE unweighted count.	of FTE residents ctions) Enter in in column 2, the the IME FTE		1.00	2.00	3.00	4.00	61. 10
61.20 Of the FTEs in line 61.05, specif program specialty, if any, and th residents for each expanded progrinstructions) Enter in column 1, enter in column 2, the program co 3, the IME FTE unweighted count a 4, direct GME FTE unweighted coun	e number of FTE am. (see the program name, de, enter in column nd enter in column				0.00	0.00	61. 20
						1.00	
					od for which	0.00	62. 00
62.01 Enter the number of FTE residents during in this cost reporting per	your hospital received HRSA PCRE funding (see instructions)						62. 01
	ts in nonprovider se	ttings	during this co		peri od? Enter	N	63. 00
Unwei ghted Unwei FTEs FTEs					Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	,
Section 5504 of the ACA Rase Vear	FTF Pasidants in No	nnrovi	dar Sattings7	1. 00	2.00	3.00	
64.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you	Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is period that begins on or after July 1, 2009 and before June 30, 2010.					0. 000000	64.00
of (column 1 divided by (column 1	Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00		2.00	3.00	4. 00 0. 00	5. 00 0. 000000	65. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  Provider CCN: 15-0045  Period: From 10/01/2015 To 09/30/2016  V  1.00  95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.  97.00 Does this hospital qualify as a critical access hospital (CAH)?  105.00 Does this hospital qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost		epared:
95. 00 If line 94 is "Y", enter the reduction percentage in the applicable column.  96. 00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  97. 00 If line 96 is "Y", enter the reduction percentage in the applicable column.  97. 00 Rural Providers  105. 00 Does this hospital qualify as a critical access hospital (CAH)?  106. 00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  107. 00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If	XI X 2. 00 0. 00 N	95. 00 96. 00
95.00   If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00 N	96. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.  105.00 Does this hospital qualify as a critical access hospital (CAH)?  106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R N training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If	N	96. 00
Rural Providers  105.00 Does this hospital qualify as a critical access hospital (CAH)?  106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If	0.00	
106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If		<b></b>
107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R N training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If		105. 00 106. 00
reimbursed. If yes complete Wkst. D-2, Pt. II.		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N  CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		108. 00
Physical         Occupational         Speech           1.00         2.00         3.00	Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	109. 00
	1.00	+
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110. 00
1.00	0 2.00 3.00	
Miscellaneous Cost Reporting Information		
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	0	115. 00
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.		116. 00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.  118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is		117. 00 118. 00
claim-made. Enter 2 if the policy is occurrence.  Premiums Losses	Insurance	1.0.00
FI elli ulis Lusses	Trisui dilce	
1.00 2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses: 337,480 23,113	i (	0 118. 01
1.00	2.00	110.00
118.02 Are malpractice premiums and paid losses reported in a cost center other than the  Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		118. 02
119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantable devices charged to Y		121. 00
patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N"  for no in column 1 if column 1 is "Y", enter in column 2 the Worksheet A line number		122. 00
where these taxes are included. Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00  f this is a Medicare certified kidney transplant center, enter the certification date		126. 00
in column 1 and termination date, if applicable, in column 2.  127.00   f this is a Medicare certified heart transplant center, enter the certification date		127. 00
in column 1 and termination date, if applicable, in column 2.		128. 00
128.00 If this is a Medicare certified liver transplant center, enter the certification date		
in column 1 and termination date, if applicable, in column 2.  129.00 If this is a Medicare certified lung transplant center, enter the certification date in		129. 00
in column 1 and termination date, if applicable, in column 2.		
in column 1 and termination date, if applicable, in column 2.  129.00 If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		129. 00 130. 00 131. 00

Health Financial Systems	DEKALB MEMORIA	L HOSPITAL			In Lie	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CCN	: 15-0045	Peri od:		Worksheet S-	2
					0/01/2015 9/30/2016		enared.
				1.0		2/23/2017 4:	
					1 00	2.00	_
133.00 If this is a Medicare certified of	ther transplant center ent	er the certific	ation date		1. 00	2. 00	133. 00
in column 1 and termination date,			atron date				100.00
134.00 If this is an organ procurement or		e OPO number in	column 1				134. 00
and termination date, if applicabl	e, in column 2.						
140.00 Are there any related organization	or home office costs as d	efined in CMS P	ub. 15-1.		N		140. 00
chapter 10? Enter "Y" for yes or '				:s			
are claimed, enter in column 2 the			ons)				
1.00 If this facility is part of a chai	2.00		h 1/3 the	name and	3.00	of the	
home office and enter the home of				rialle and	addi ess	or the	
141. 00 Name:	Contractor's Name:			tor's Nu	mber:		141. 00
142.00 Street:	PO Box:		7. 0				142.00
143. 00 Ci ty:	State:		Zi p Coc	le:			143. 00
						1. 00	+
144.00 Are provider based physicians' cos	sts included in Worksheet A	.?				Y	144. 00
145.00 If costs for renal services are cl	-: NII+ A Lin- 74	414-	£		1. 00 N	2.00	1.45 0/
inpatient services only? Enter "Y'					IN		145. 00
no, does the dialysis facility ind	clude Medicare utilization						
period? Enter "Y" for yes or "N"							
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in				£	N		146. 00
yes, enter the approval date (mm/c		5-2, Chapter 40	i, 94020) i	'			
Type of the approval date (IIIII)	24, 11, 11, 20, 4, 11, 2, 2, 1						
T						1.00	
147.00 Was there a change in the statisti 148.00 Was there a change in the order of						N N	147. 00 148. 00
149.00 Was there a change to the simplifi				nr no		N N	149. 00
177. 00 mas there a change to the simplifit	ed cost irriding method. En	Part A	Part B		itle V	Title XIX	117.00
		1. 00	2. 00		3. 00	4. 00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or '155.00 Hospi tal	N FOR HO FOR EACH COMPONE	N N	N N	(See 42	N 9413	N N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157.00 Subprovider - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. OO SNF 160. OO HOME HEALTH AGENCY		N N	N N		N N	N N	159. 00 160. 00
161. 00 CMHC		IN .	N		N	N N	161. 00
161. 10 CORF			N		N	N	161. 10
		·					
Multicampus						1.00	
165.00 Is this hospital part of a Multica	ampus hospital that has one	or more campus	es in diff	erent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.							
	Name	County		ip Code	CBSA	FTE/Campus	_
166.00  f  ine 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5. 00	0 166. 00
campus enter the name in column						0.0	100.00
O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
corumn 5 (see thistructions)							
						1.00	
Health Information Technology (HI				ent Act			
167.00 Is this provider a meaningful user				) cn+c-	+ho	Y	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			10/ IS Y	), enter	trie		0168.00
168.01 If this provider is a CAH and is r			qualify fo	or a hard	shi p		168. 0°
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or "N"	for no. (see in	structions	s)	•		
169.00 If this provider is a meaningful u		is not a CAH (I	ine 105 is	s "N"), e	nter the	9.9	9169. 0
transition factor. (see instruction	נפוונ)						1

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX II	PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0045 F				2
			From 10/01/2015 To 09/30/2016		anarad.
			To 09/30/2016	Date/Time Pre 2/23/2017 4:5	
			Begi nni ng	Endi ng	
	1. 00	2.00			
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				12/29/2016	170. 00
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provide	171.00  f  ine 167 is "Y", does this provider have any days for individuals enrolled in				
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter					
"Y" for yes and "N" for no in column	<ol> <li>If column 1 is yes, er</li> </ol>	nter the number of sectio	on		
1876 Medicare days in column 2. (see	instructions)				

	Financial Systems DEKALB MEMORI TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0045	Period: From 10/01/2015	Worksheet S-2 Part II	2
				To 09/30/2016	2/23/2017 4:5	epared 56 pm
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	esponses. Ente	1.00 er all dates in t	2.00 The	
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hoginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions)			1. (
			1. 00	2. 00	V/I 3. 00	+
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N	3.00		2.
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home commedical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	А	11/23/2016	4.0
00	Are the cost report total expenses and total revenues differentiates on the filed financial statements? If yes, submit reconstructions on the filed financial statements?		N			5.
		CONCITTATION.		Y/N 1. 00	Legal Oper. 2.00	
00	Approved Educational Activities  Column 1: Are costs claimed for nursing school? Column 2:	If ves. is th	ne provider is	s N		6.
00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	,	.o p. ov. do	N		7.
00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved		G	N N		8.
. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program in itiated of	is.		N		10.
. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N		11.
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
	Bad Debts				1. 00	
. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 13.
. 00	period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structi ons.	N	14.
. 00	Did total beds available change from the prior cost reporti	, , , , , , , , , , , , , , , , , , , ,			Υ	15.
		Y/N	t A Date	Par Y/N	t B Date	
		1.00	2.00	3. 00	4. 00	
00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	02/16/2017	Y	02/16/2017	16.
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17.
00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.

Heal th	Financial Systems DEKALB MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 15-0045	Peri od: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Pre 2/23/2017 4:5	pared:
		Descri	pti on	Y/N	Y/N	) piii
			)	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
		Y/N	Date 2.00	Y/N	Date	
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2.00	3. 00 N	4. 00	21. 00
	records? If yes, see instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PT CHILDRENS H	OSPI TALS)			-
22. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	d into during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	e cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	Υ	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matu	N	30. 00			
31. 00	instructions. Has debt been recalled before scheduled maturity without is instructions.	N	31. 00			
32. 00 33. 00	Purchased Services  Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If					
	no, see instructions. Provider-Based Physicians			l		
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	sed physi ci ans?	Y	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based	N	35. 00
				Y/N	Date	
	U 066: C+-			1. 00	2. 00	
24 00	Home Office Costs			NI NI		24 00
	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been profite cost statement been profite cost statement.	epared by the	home office?	N		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end					38. 00
39. 00	If line 36 is yes, did the provider render services to othe see instructions.			,		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00
		1	00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI		41. 00
42. 00		BLUE AND CO.,	LLC			42. 00
43. 00		317-713-7959		MALESSANDRI NI @E	BLUEANDCO. COM	43. 00

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CM				
	From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Pre 2/23/2017 4:5	pared:	
3. 00				
DI RECTOR			41.00	
			42. 00	
			43.00	
3,	Provi der CCN: 15-0045  3.00	Provi der CCN: 15-0045   Peri od: From 10/01/2015 To 09/30/2016	Provi der CCN: 15-0045   Peri od: From 10/01/2015   To 09/30/2016   Provider II Date/Time Pre 2/23/2017 4: 5	

					10	09/30/2010	2/23/2017 4:5	
							I/P Days / 0/P	, p
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		48		0.00		1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			48	17, 568	0. 00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		8	2, 928	0. 00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			56	20, 496	0. 00		14. 00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24. 00	HOSPI CE	116. 00		0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			56				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00

| Peri od: | Worksheet S-3 | From 10/01/2015 | Part I | To 09/30/2016 | Date/Time Prepared:

				''	0 07/30/2010	2/23/2017 4: 5	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	<u>5 piii</u>
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	oomponon:			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	1, 763	267	4, 972			1. 00
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	1, 523	1, 337				2. 00
3.00	HMO IPF Subprovider	o	o				3.00
4.00	HMO IRF Subprovider	o	o				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		o	0			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 763	267	4, 972			7. 00
8.00	INTENSIVE CARE UNIT	461	o	1, 490			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		o	860			13.00
14.00	Total (see instructions)	2, 224	267	7, 322	0.00	488. 22	14.00
15.00	CAH visits	O	o	0			15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	3, 167	o	9, 024	0.00	13. 74	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	o	o	64	0.00	1. 03	24.00
24. 10	HOSPICE (non-distinct part)	o	o	0			24. 10
25.00	CMHC - CMHC						25.00
25. 10	CMHC - CORF	o	o	0	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	o	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	502. 99	27.00
28. 00	Observation Bed Days		19	1, 501			28.00
29. 00	Ambul ance Trips	1, 190					29.00
30.00	Employee discount days (see instruction)			92			30.00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	О	3			32. 00
32. 01	Total ancillary labor & delivery room	1	٦	0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00

 
 Heal th Financial
 Systems
 DEKALB

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-0045

				To	09/30/2016	Date/Time Prep   2/23/2017 4:50	
		Full Time		Di sch	arges	2/23/2017 4. 30	J DIII
		Equi val ents			9		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	667	56	2, 179	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			407	250		2 00
2.00	HMO and other (see instructions)			427	359 0		2. 00 3. 00
3. 00 4. 00	HMO IPF Subprovider HMO IRF Subprovider				U O		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF				٩		5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNI						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	C	667	56	2, 179	14.00
15. 00	CAH visits						15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY	0. 00					21. 00 22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions)						33. 00
33. UU	LTCH non-covered days						JJ. UU

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

| Peri od: | Worksheet S-3 | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared:

					To	09/30/2016	Date/Time Prep 2/23/2017 4:50	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from	(col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
	•	1.00	2. 00	Worksheet A-6) 3.00	3) 4. 00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	3. 00	0.00	
1. 00	SALARIES Total salaries (see	200. 00	27, 340, 435	0	27 240 425	1 042 240 00	26. 21	1.00
1.00	instructions)	200.00	27, 340, 433		27, 340, 435	1, 043, 248. 00	20. 21	1.00
2.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2. 00
3.00	A Non-physician anesthetist Part		0	0	О	0.00	0. 00	3.00
4. 00	Physician-Part A -		278, 550	0	278, 550	2, 116. 00	131. 64	4.00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0. 00	4. 01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	О	0	0.00	0.00	7. 01
8. 00	programs) Home office and/or related		0	0	0	0.00	0. 00	8. 00
9. 00	organization personnel SNF	44. 00	0	0	0	0.00	1	
10. 00	Excluded area salaries (see instructions)		8, 727, 896	0	8, 727, 896	264, 716. 00	32. 97	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		1, 049, 370	0	1, 049, 370	17, 300. 00	60. 66	11. 00
12. 00	Care Contract Labor: Top Level		0,017,070		., ,	0.00		12.00
12.00	management and other management and administrative		O		0	0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part		383, 345	0	383, 345	2, 046. 00	187. 36	13.00
14. 00	A - Administrative Home office and/or related orgainzation salaries and		0	О	0	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		0	О	О	0.00	0.00	14. 01
14. 02	Related organization salaries		0	0	0	0.00		
15. 00	Home office: Physician Part A   - Administrative		0	0	0	0.00	0.00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16.00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		5, 853, 903	Ιο	5, 853, 903			   17. 00
18. 00	instructions) Wage-related costs (other)		0		0,000,000			18. 00
	(see instructions)		_	_				
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		2, 048, 940 0	0	2, 048, 940 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21.00
22. 00	B Physician Part A -		20, 848	0	20, 848			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		0	ő	o o			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0	0	0			24. 00 25. 00
25. 50 25. 51	Home office wage-related Related orgainzation		0	1	0			25. 50 25. 51
25. 52	wage-related Home office: Physician Part A		0	0	0			25. 52
	- Administrative - wage-related							
25. 53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25. 53
2/ 22	OVERHEAD COSTS - DIRECT SALARIE		00.1.1==		20: :5-	7 404	21.5	
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	234, 489 3, 623, 118			7, 481. 00 174, 753. 00		26. 00 27. 00
	,	2. 00	.,,	,	,,	.,		,

| Peri od: | Worksheet S-3 | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared:

					'	0 07/30/2010	2/23/2017 4: 5	
	·	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		238, 625	0	238, 625	1, 228. 00	194. 32	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	576, 302	0	576, 302	i i		
31. 00	Laundry & Linen Service	8. 00	16, 181	0	16, 181			
32.00	Housekeepi ng	9. 00	683, 583	0	683, 583	51, 527. 00	13. 27	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	582, 872	-350, 420	232, 452	10, 936. 00	21. 26	34.00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	350, 420	350, 420	23, 488. 00	14. 92	
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38.00	Nursing Administration	13. 00	825, 105	0	825, 105	22, 625. 00	36. 47	38. 00
39. 00	Central Services and Supply	14. 00	89, 571	0	89, 571	5, 573. 00	16. 07	39. 00
40.00	Pharmacy	15. 00	516, 534	0	516, 534	12, 295. 00	42. 01	40.00
41.00	Medical Records & Medical	16. 00	499, 678	0	499, 678	26, 728. 00	18. 69	41.00
	Records Library							
42.00	Social Service	17. 00	71, 811	0	71, 811	2, 067. 00	34. 74	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| Peri od: | Worksheet S-3 | From 10/01/2015 | Part III | To 09/30/2016 | Date/Time Prepared:

					'	0 077 007 2010	2/23/2017 4: 50	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		27, 579, 060	0	27, 579, 060	1, 044, 476. 00	26. 40	1.00
	instructions)							
2.00	Excluded area salaries (see		8, 727, 896	0	8, 727, 896	264, 716. 00	32. 97	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		18, 851, 164	0	18, 851, 164	779, 760. 00	24. 18	3. 00
	minus line 2)							
4. 00	Subtotal other wages & related		1, 432, 715	0	1, 432, 715	19, 346. 00	74. 06	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		5, 874, 751	0	5, 874, 751	0.00	31. 16	5. 00
	(see inst.)							
6. 00	Total (sum of lines 3 thru 5)		26, 158, 630		26, 158, 630		1	
7. 00	Total overhead cost (see		7, 957, 869	0	7, 957, 869	364, 698. 00	21. 82	7. 00
	instructions)							

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0045	
		From 10/01/2015   Part IV

	To 09/30/2016	Date/Time Prep 2/23/2017 4:50	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	102, 470	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	1, 500	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	5, 431, 702	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	61, 887	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	69, 733	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	295, 952	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	1, 844, 270	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	17, 572	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	98, 604	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7, 923, 690	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 15-0045	From 10/01/2015 To 09/30/2016	Worksheet S-3 Part V Date/Time Prepared:

		0 09/30/2016	Date/lime Prep   2/23/2017 4:50	
	Cost Center Description	Contract Labor	Benefit Cost	<b>У</b> Ріп
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - IRF			4. 00
5. 00	Subprovi der - (0ther)	0	0	5. 00
6. 00	Swing Beds - SNF	0	0	6. 00
7. 00	Swing Beds - NF	0	0	7. 00
8. 00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10. 00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	0	0	
	Separately Certified ASC			12.00
	Hospi tal -Based Hospi ce	0	0	
	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
	Hospi tal -Based-CMHC			16. 00
	Hospi tal -Based-CMHC 10	0	0	
	Renal Di al ysi s			17. 00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems	DEKALB MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	EALTH AGENCY STATISTICAL DATA		Provi der C	CN: 15-0045 CCN: 15-7157	Peri od: From 10/01/2015 To 09/30/2016	Worksheet S-4 Date/Time Pre	pared:
					Home Health	2/23/2017 4: 5 PPS	6 pm
					Agency I		
					1.	00	
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2. 00	3.00	4. 00	5. 00	
1 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours		0	I	0 0	0	1.00
1. 00 2. 00	Unduplicated Census Count (see instructions)	0.00	181. 00	1			
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the number	er of hours in	Staff	Contract	Total	
		your normal	work week				
		0		1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	0.0	0.00	0.00	3.00
4. 00	Director(s) and Assistant Director(s)		0.00	0.0		0.00	1
5.00	Other Administrative Personnel			0.0		0.00	1
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			0.0		0. 00 0. 00	1
8.00	Physical Therapy Service			0.0		0.00	
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0.0		0. 00 0. 00	1
11. 00	Occupational Therapy Supervisor			0.0			1
12. 00	Speech Pathology Service			0.0		0.00	
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0.0		0. 00 0. 00	1
15. 00	Medical Social Service Supervisor			0.0	0.00	0. 00	15. 00
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			0.0		0. 00 0. 00	1
18. 00	Other (specify)			0.0			1
10.00	HOME HEALTH AGENCY CBSA CODES			I	ما		10.00
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				2		19. 00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			50031			20.00
20.00	during this cost reporting period (line 20			30031			20.00
20. 01	contains the first code).			99915			20. 01
		Full Ep			555.01		
		Without Outliers	With Outliers	LUPA Epi sode	es PEP Only Epi sodes	Total (cols. 1-4)	
	DDC ACTIVITY DATA	1.00	2. 00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 544	112		68 30	1, 754	21. 00
22. 00	Skilled Nursing Visit Charges	289, 734	21, 000			329, 109	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	697 125, 955	742	9:	5 17 28 3, 154	723 130, 779	
25. 00	Occupational Therapy Visits	111	6		0 0	117	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	20, 063 25	1, 125 0	1	0 0	21, 188 26	1
28. 00	Speech Pathology Visit Charges	4, 981	0	l .	99 0	5, 180	28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	8 2, 280	1 285	20	1 0 85 0	10 2, 850	•
31. 00	Home Health Aide Visits	506	21	1	2 8	537	1
32.00	Home Health Aide Visit Charges	56, 293	2, 336		23 890	59, 742	
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2, 891	144		77 55	3, 167	33. 00
34.00	Other Charges	0	25, 400	14.0	0 0	0	
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	499, 306	25, 488			548, 848	35. 00
36. 00	Total Number of Episodes (standard/non outlier)	179			29 4	212	36. 00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	17, 694	5 14, 812		0 14	5 32 520	37. 00 38. 00
30.00	Total Mon-Routine medical Supply charges	17,094	14, 012	1	- 14	32, 320	1 30.00

Heal th	Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	AL-BASED HOSPICE IDENTIFICATION	DATA		Provi der C	CN: 15-0045	Peri od:	Worksheet S-9	
				Hospi so CCI	N: 15-1559	From 10/01/2015 To 09/30/2016	PARTS I THROUG Date/Time Pre	GH IV
				nospi ce cci	N. 13-1339	10 09/30/2010	2/23/2017 4:50	
-						Hospi ce I		-
		Unduplicated						
		Days		_				
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursing Facility	Facility		5)	
		1, 00	2.00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO					3.00	0.00	
1.00	Hospice Continuous Home Care		2.1. 050 520.11.11		1			1.00
2.00	Hospice Routine Home Care							2. 00
3.00	Hospice Inpatient Respite Care							3. 00
4.00	Hospice General Inpatient Care							4. 00
5.00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving							6. 00
7.00	hospi ce care							7.00
7. 00	Total number of unduplicated Continuous Care hours billable							7. 00
	to Medicare							
8. 00	Average Length of Stay (line 5							8. 00
0.00	/ line 6)							0.00
9.00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
	DART LLL ENDOLLMENT DAVO FOR	2227 DEBODELLI	DEDI 000 DE011	1.00	2.00	3. 00	4. 00	
10.00	PART III - ENROLLMENT DAYS FOR Hospice Continuous Home Care	COST REPORTING	PERIODS BEGIN	INING ON OR AFT	ER OCTOBER 1,	, 2015	0	10.00
10. 00 11. 00	· ·			2, 889		87 1, 036	4 013	10. 00 11. 00
12. 00	Hospice Inpatient Respite Care			2,889		0 0	4,012	
13. 00				52		16 16	· ·	13. 00
14. 00				2, 950		03 1, 052		14. 00
14.00	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	ST REPORTING PE					1 7. 00
15. 00				0		0 0		15. 00
	Hospice General Inpatient Care			0		0 0		
	•			•	•		. '	•

Hoal th	Financial Systems	DEKALB MEMORIAL	HUSDI TVI		In lie	u of Form CMS-2	2552_10	
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	DERAED WEWORTAL	Provider CO	N: 15_0045	Peri od:	Worksheet S-10		
HOSEL	THE UNCOMPENSATED AND THUTGENT CARE DATA		Frovider Co	SN. 13-0043	From 10/01/2015 To 09/30/2016		pared:	
	·						•	
						1. 00		
	Uncompensated and indigent care cost computat							
1.00	Cost to charge ratio (Worksheet C, Part I li	ne 202 column 3 di	vided by li	ne 202 colum	n 8)	0. 305480	1.00	
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid					4, 376, 759	2. 00	
3.00	Did you receive DSH or supplemental payments					N	3. 00	
4.00	If line 3 is "yes", does line 2 include all I			from Medicai	d?		4. 00	
5.00	If line 4 is "no", then enter DSH or supplement	ental payments fro	om Medicaid			0	5. 00	
6.00	Medi cai d charges					20, 472, 935	1	
7.00	Medicaid cost (line 1 times line 6)					6, 254, 072	7. 00	
8.00	Difference between net revenue and costs for	Medicaid program	(line 7 min	us sum of li	nes 2 and 5; if	1, 877, 313	8. 00	
	< zero then enter zero)							
	Children's Health Insurance Program (CHIP) (s	see instructions 1	or each lin	e)				
9. 00	Net revenue from stand-alone CHIP					0	9. 00	
10. 00	3					0	10. 00	
11. 00	,					0	11. 00	
12. 00		stand-alone CHIP	(line 11 mi	nus line 9;	if < zero then	0	12. 00	
	enter zero)							
	Other state or local government indigent care					_		
13. 00	9	1 5 1			,	0	13. 00	
14. 00		ocal indigent car	e program (	Not included	in lines 6 or	0	14. 00	
45.00	10)		. 45			0	45.00	
15. 00					15 1:	0	15.00	
16. 00		state or Local II	ndigent care	program (II	ne 15 minus line	0	16. 00	
	13; if < zero then enter zero) Uncompensated care (see instructions for each	lino)						
17. 00			funding char	ity care		0	17. 00	
18. 00						209, 233		
19. 00					e (sum of lines	1, 877, 313	•	
17.00	8, 12 and 16)	and State and rock	ii indigent	care program	3 (Sum of Titles	1,077,313	17.00	
	107 12 and 107			Uni nsured	Insured	Total (col. 1		
				pati ents	pati ents	+ col . 2)		
				1.00	2.00	3. 00		
20. 00	Charity care charges for the entire facility	(see instructions	s)	904, 0	00 0	904, 000	20. 00	
21.00	Cost of patients approved for charity care (	line 1 times line	20)	276, 1	54 0	276, 154	21. 00	
22. 00	Partial payment by patients approved for chair	rity care			0 0	0		
23.00	Cost of charity care (line 21 minus line 22)			276, 1	54 0	276, 154	23. 00	
						1. 00		
24. 00	Does the amount in line 20 column 2 include of			nd a Length	of stay limit	N	24. 00	
	imposed on patients covered by Medicaid or other indigent care program?							
25. 00								
26. 00			,			5, 648, 118	1	
27. 00						101, 490	1	
28. 00						5, 546, 628		
29. 00			opense (line	1 times lin	e 28)	1, 694, 384	•	
30. 00		'				1, 970, 538		
31. 00	Total unreimbursed and uncompensated care cos	st (line 19 plus l	ıne 30)			3, 847, 851	31.00	

Heal th	Financial Systems	DEKALB MEMORIA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		Peri od:	Worksheet A	
					From 10/01/2015 To 09/30/2016	Date/Time Pre	narodi
					10 09/30/2010	2/23/2017 4:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	, p
	·			+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
	OFFICE ASSET OF THE PARTY OF TH	1.00	2. 00	3.00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS		F 040 400	5 040 40		F 040 400	4 00
1. 00 1. 01	OO100   CAP REL COSTS-BLDG & FIXT   OO101   MAC WEST - NEW		5, 342, 102	1		5, 342, 102	
1.01	00101 MAC WEST - NEW		23, 501 4, 584			23, 501 4, 584	1. 01 1. 02
1.02	00103 GARRETT CLINIC - NEW		16, 587	1			
1. 03	00104 BUTLER - NEW		11, 914			11, 914	
1. 05	00105 MAC EAST - NEW		150, 192	1			
1.06	00106 GARRETT LAB - NEW		100, 172		0	0	1
1. 07	00107 MEDI CAL ARTS - NEW		43, 183	1	-	43, 183	
1.08	00108 DAY SPRING - NEW		0		0	0	1. 08
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		0	0	2. 00
3.00	00300 OTHER CAP REL COSTS		0		0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	234, 489	438, 693	673, 18	2 0	673, 182	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 623, 118	6, 855, 519	10, 478, 63	7 -9, 317	10, 469, 320	
7.00	00700 OPERATION OF PLANT	576, 302	1, 576, 184	2, 152, 48	6 0	2, 152, 486	
8.00	00800 LAUNDRY & LINEN SERVICE	16, 181	7, 868			24, 049	
9.00	00900 HOUSEKEEPI NG	683, 583	496, 812			1, 180, 395	
10.00	01000 DI ETARY	559, 878	538, 629	1			
10. 01	01001 SNACK BAR	22, 994	36, 021			59, 015	
	01100 CAFETERI A	0	172 403	1	700, 270		
13.00	01300 NURSI NG ADMI NI STRATI ON	825, 105	172, 403	1		997, 508	
	01400 CENTRAL SERVICES & SUPPLY	89, 571	119, 825			209, 396	
15. 00 16. 00	01500   PHARMACY   01600   MEDI CAL RECORDS & LI BRARY	516, 534 499, 678	48, 984 159, 853	1		565, 518 659, 531	1
	01700 SOCIAL SERVICE	71, 811	18, 451	1			1
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	71,011	10, 431	70, 20.	2  0	70, 202	17.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 902, 810	1, 247, 188	4, 149, 99	- 795, 629	3, 354, 369	30.00
31.00	03100 INTENSIVE CARE UNIT	969, 366	583, 108	1		1, 552, 474	
43.00	04300 NURSERY	0	1, 024	1, 02	4 267, 101	268, 125	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	1, 588, 250	1, 944, 906				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1 225 427	1	528, 528		
54. 00 60. 00	05400  RADI OLOGY-DI AGNOSTI C   06000  LABORATORY	1, 756, 665	1, 325, 437	1		3, 056, 995 3, 549, 184	
60. 00	06001 BLOOD LABORATORY	1, 287, 928	2, 261, 256	3, 349, 10	0	3, 349, 104 1	60.00
65. 00	06500 RESPIRATORY THERAPY	527, 684	152, 121	679, 80	5 0	679, 805	
66. 00	06600 PHYSI CAL THERAPY	320, 975	1, 162, 883				
66. 01	06601 CARDI AC REHAB	100, 116	32, 398	1		184, 631	
69.00	06900 ELECTROCARDI OLOGY	47, 534	5, 731	53, 26	5 25, 107	78, 372	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	49, 294	29, 760	1			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	1, 750, 867			1, 750, 867	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 121, 414			1, 121, 414	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 029, 778	3, 029, 77	8 0	3, 029, 778	/3.00
00 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	58, 723	7, 558	66, 28	1 0	66, 281	90.00
	09100 EMERGENCY	1, 283, 950	457, 270	1			
	09200 OBSERVATION BEDS (NON-DISTINCT	1, 203, 730	437, 270	1, 771, 22	3	1, 741, 220	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 155, 404	527, 478	1, 682, 88	2 0	1, 682, 882	95. 00
99. 10	09910 CORF	o	0		0 0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	744, 256	406, 627	1, 150, 88	5, 275	1, 156, 158	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300   I NTEREST EXPENSE		0		0		113. 00
	11600 HOSPI CE	79, 924	205, 204			285, 699	
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	20, 592, 123	32, 313, 313	52, 905, 43	6 -3, 471	52, 901, 965	]118.00
100 00	19000 GIFT FLOWER COFFEE SHOP & CAN		0	N .	0 (	0	190. 00
	19100 RESEARCH		0		0		191.00
	19200 PHYSICIANS PRIVATE OFFICES		Ö		0		192. 00
	19201 DEKALB MEDI CAL SERVI CES	6, 291, 947	2, 617, 965	8, 909, 91	2 3, 471		
	19202 PHARMACARE	447, 163	3, 942, 139	1		4, 389, 302	
193.00	19300 NONPALD WORKERS	0	0		0 0	0	193. 00
	07950 OTHER NONREIMBURSABLE COST CENT		0	)	0 (C		194. 00
	07951 ADULT DAY CARE	0	0		0		194. 01
	07952 FOUNDATION	9, 202	4, 288	1			194. 02
200.00	TOTAL (SUM OF LINES 118-199)	27, 340, 435	38, 877, 705	66, 218, 14	0	66, 218, 140	1200.00

 
 Health Financial
 Systems
 DEKALB MEM

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-0045 Peri od: From 10/01/2015 To 09/30/2016 Worksheet A Date/Time Prepared: 2/23/2017 4:56 pm Cost Center Description Adjustments Net Expenses

		cost center bescription	,	For Allocation		
			6.00	7. 00		
	GENER.	AL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-383, 778	4, 958, 324		1. 00
1.01	00101	MAC WEST - NEW	0	23, 501		1. 01
1.02		NORTH ANNEX - NEW	0	4, 584		1. 02
1.03	1	GARRETT CLINIC - NEW	0	16, 587		1. 03
1.04	1	BUTLER - NEW	0	11, 914		1. 04
1. 05		MAC EAST - NEW	0	150, 192		1. 05
1.06		GARRETT LAB - NEW	0	0	1	1. 06
1.07		MEDICAL ARTS - NEW	0	43, 183		1. 07
1.08	1	DAY SPRING - NEW	0	0		1. 08
2.00	1	CAP REL COSTS-MVBLE EQUIP	0	0	1	2.00
3.00		OTHER CAP REL COSTS	1 505	0	•	3. 00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	-1, 585 -1, 717, 752			4. 00 5. 00
7. 00		OPERATION OF PLANT	-1, 717, 752 -3, 928			7. 00
8.00	1	LAUNDRY & LINEN SERVICE	-3, <del>92</del> 6 -896			8. 00
9. 00		HOUSEKEEPI NG	-2, 683	l		9. 00
10.00		DI ETARY	-6, 004			10.00
10. 01	1	SNACK BAR	-51, 998	l	l control of the cont	10. 01
11. 00	1	CAFETERI A	-266, 827	l	1	11. 00
13. 00		NURSI NG ADMI NI STRATI ON	-75	l		13. 00
14.00		CENTRAL SERVICES & SUPPLY	0	l .		14. 00
15.00		PHARMACY	0	565, 518	1	15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1, 140	658, 391		16. 00
17.00	01700	SOCIAL SERVICE	0	90, 262		17. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-65, 000	3, 289, 369		30. 00
31.00		INTENSIVE CARE UNIT	-59, 625	1, 492, 849		31. 00
43.00		NURSERY	0	268, 125	j	43. 00
		LARY SERVICE COST CENTERS				4
50. 00		OPERATI NG ROOM	-811, 122			50. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	020, 020		52. 00
54. 00		RADI OLOGY-DI AGNOSTI C	-55, 615			54.00
60.00	1	LABORATORY	42			60.00
60. 01	1	BLOOD LABORATORY	0	1	l .	60. 01
65. 00	1	RESPI RATORY THERAPY	-267	679, 538	l control of the cont	65. 00
66. 00 66. 01		PHYSI CAL THERAPY CARDI AC REHAB	-24, 654 -13, 249	1		66. 00 66. 01
69. 00		ELECTROCARDI OLOGY	-13, 249 -1, 200	l		69. 00
70. 00		ELECTROENCEPHALOGRAPHY	-1, 200	I		70. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PAT	0	1		71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	1, 121, 414		72.00
73. 00		DRUGS CHARGED TO PATIENTS	-201	3, 029, 577		73. 00
		TIENT SERVICE COST CENTERS		5/ 52 - 1/ 51 - 1		1
90.00		CLI NI C	0	66, 281		90.00
91.00		EMERGENCY	0	1, 741, 220		91. 00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92. 00
		REIMBURSABLE COST CENTERS				
		AMBULANCE SERVICES	-278, 352		1	95. 00
99. 10			0	1		99. 10
101.00		HOME HEALTH AGENCY	-8, 144	1, 148, 014		101. 00
		AL PURPOSE COST CENTERS	_	г _		4
		I NTEREST EXPENSE	0	0		113. 00
		HOSPI CE	-173			116. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS	-3, 754, 226	49, 147, 739		118. 00
100.00		GIFT FLOWER COFFEE SHOP & CAN	0	0	<u> </u>	190. 00
		RESEARCH	0			191. 00
		PHYSICIANS PRIVATE OFFICES	0			191.00
		DEKALB MEDICAL SERVICES	0	8, 913, 383	l .	192. 00
		PHARMACARE	-6, 127	4, 383, 175		192. 02
		NONPALD WORKERS	0, 127	0	1	193. 00
		OTHER NONREIMBURSABLE COST CENT	0	Ö	•	194. 00
		ADULT DAY CARE	0	Ö	1	194. 01
		FOUNDATI ON	0	13, 490	1	194. 02
200.00		TOTAL (SUM OF LINES 118-199)	-3, 760, 353	l		200. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS		Peri od: Worksheet A-6 From 10/01/2015
		To 09/30/2016 Date/Time Prepared: 2/23/2017 4:56 pm

					2/23/2017 4:56 pm
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4.00	5. 00	
	A - CAFETERIA RECLASS				
1.00	CAFETERI A	1100	350, 420	349, 850	1. 00
	0		350, 420	349, 850	
	C - LABOR DELIVERY NURSERY				
1.00	NURSERY	43.00	172, 934	94, 167	1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	342, 194	186, 334	2. 00
	0		515, 128	280, 501	
	D - NORTH ANNEX RECLASS				
1.00	HOME HEALTH AGENCY	101.00	0	5, 275	1. 00
2.00	HOSPI CE	116.00	0	571	2. 00
3.00	DEKALB MEDICAL SERVICES	192.01	0	3, 471	3. 00
	0		0	9, 317	
	E - REHABILITATION OFFICE REC	CLASS			
1.00	CARDI AC REHAB	66. 01	46, 273	5, 844	1. 00
	0		46, 273	5, 844	
	F - RADIOLOGY ADMIN RECLASS				
1.00	ELECTROCARDI OLOGY	69.00	12, 484	12, 623	1. 00
	0		12, 484	12, 623	
500.00	Grand Total: Increases		924, 305	658, 135	500.00

Heal th	Financial Systems		DEKALB MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLASS	SIFICATIONS			Provi der (	CCN: 15-0045	Peri od: From 10/01/2015	Worksheet A-6	)
						To 09/30/2016	Date/Time Pre 2/23/2017 4:5	
		Decreases						
	Cost Center	line #	Salary	Other	Wkst A-7 Ref	,		

						2/23/201/ 4:56 pm	_
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	<u>:</u>	
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	1000	350, 420	349, 850		0 1.00	1
	0		350, 420	349, 850			
	C - LABOR DELIVERY NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	515, 128	280, 501		0 1.00	1
2.00		0.00		0		0 2.00	1
	0		515, 128	280, 501			
	D - NORTH ANNEX RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	9, 317		0 1.00	1
2.00		0.00	0	0		0 2.00	1
3.00		0.00	0	0		0 3.00	1
	0		0	9, 317			
	E - REHABILITATION OFFICE REC	LASS					
1.00	PHYSICAL THERAPY	6600	4 <u>6, 2</u> 73	<u>5, 8</u> 44		0 1.00	1
	0		46, 273	5, 844			
	F - RADIOLOGY ADMIN RECLASS						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	12, 484	1 <u>2, 6</u> 23		0 1.00	1
	0		12, 484	12, 623			
500.00	Grand Total: Decreases		924, 305	658, 135		500.00	1

				T	09/30/2016	Date/Time Pre	
						2/23/2017 4:5	6 pm
				Acqui si ti ons	<b>+</b>		
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances	0.00	0.00	4.00	Retirements	
	DART I ANALYCIC OF QUANCES IN CARLTAL ACCE	1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		ما				
1.00	Land	393, 118		0	0	0	1. 00
2.00	Land Improvements	1, 781, 970	48, 740	0	48, 740	0	2. 00
3.00	Buildings and Fixtures	60, 294, 655	772, 528	0	772, 528	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	24, 276, 380	0	0	0	35, 147	6. 00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	86, 746, 123	821, 268	0	821, 268	35, 147	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	86, 746, 123	821, 268	0	821, 268	35, 147	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	393, 118	0				1. 00
2.00	Land Improvements	1, 830, 710	0				2. 00
3.00	Buildings and Fixtures	61, 067, 183	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equi pment	0	0				5. 00
6.00	Movable Equipment	24, 241, 233	o				6.00
7.00	HIT designated Assets	0	o				7. 00
8.00	Subtotal (sum of lines 1-7)	87, 532, 244	ol				8. 00
9.00	Reconciling Items	0	o				9. 00
10. 00	Total (line 8 minus line 9)	87, 532, 244	0				10.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS DEKALB MEMORIAL HOSPITAL

Provider CCN: 15-0045

					o 09/30/2016		
			SL	JMMARY OF CAPIT	AL	272072017 1.0	O piii
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUMN	12, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	4, 958, 324	0	383, 778	0	0	1.00
1.01	MAC WEST - NEW	23, 501	0	C	0	0	1. 01
1.02	NORTH ANNEX - NEW	4, 584	0	C	0	0	1. 02
1.03	GARRETT CLINIC - NEW	16, 587	0	C	0	0	1. 03
1.04	BUTLER - NEW	11, 914	0	C	0	0	1. 04
1.05	MAC EAST - NEW	150, 192	0	C	0	0	1. 05
1.06	GARRETT LAB - NEW	o	0	C	0	0	1.06
1.07	MEDICAL ARTS - NEW	43, 183	0	l c	0	0	1. 07
1.08	DAY SPRING - NEW	o	0	C	0	0	1. 08
2.00	CAP REL COSTS-MVBLE EQUIP	o	0	l c	0	0	2. 00
3.00	Total (sum of lines 1-2)	5, 208, 285	0	383, 778	0	0	3. 00
		SUMMARY OF	CAPITAL				
	Cost Center Description		Гotal (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00	L			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	(SHEET A, COLUMN	·				
1.00	CAP REL COSTS-BLDG & FIXT	0	5, 342, 102				1.00
1.01	MAC WEST - NEW	0	23, 501				1. 01
1.02	NORTH ANNEX - NEW	0	4, 584				1. 02
1.03	GARRETT CLINIC - NEW	0	16, 587				1.03
1.04	BUTLER - NEW	0	11, 914				1.04
1.05	MAC EAST - NEW	0	150, 192				1.05
1.06	GARRETT LAB - NEW	0	0				1. 06
1.07	MEDICAL ARTS - NEW	0	43, 183				1. 07
1.08	DAY SPRING - NEW	0	0				1. 08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5, 592, 063	l			3. 00

	CILIATION OF CAPITAL COSTS CENTERS	DERAED MEMORI	Provi der C		eri od:	Worksheet A-7	1002 10
					rom 10/01/2015 o 09/30/2016	Date/Time Prep	
		COMPUTATION OF RATIOS			ALLOCATION OF	5 pm	
		COMPUTATION OF RATIOS			ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col. 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	63, 291, 011				0	1. 00
1.01	MAC WEST - NEW	0	1			0	1. 01
1. 02 1. 03	NORTH ANNEX - NEW GARRETT CLINIC - NEW	0	0	0		0	1. 02 1. 03
1.03	BUTLER - NEW	0				0	1. 03
1. 05	MAC EAST - NEW	0		Ö		0	1. 05
1.06	GARRETT LAB - NEW	0	0	C		0	1. 06
1.07	MEDICAL ARTS - NEW	0	0	C	0. 000000	0	1. 07
1.08	DAY SPRING - NEW	0	0	C	0. 000000	0	1. 08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	C	0. 000000	0	2. 00
3. 00	Total (sum of lines 1-2)	63, 291, 011		63, 291, 011		O CADITAL	3. 00
		ALLUCA	TION OF OTHER (	CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Rel ate				
			d Costs	through 7)			
	PART III - RECONCILIATION OF CAPITAL COSTS CE	6. 00	7. 00	8. 00	9. 00	10. 00	
1.00	CAP REL COSTS-BLDG & FIXT	INTERS 0		0	4, 958, 324	0	1. 00
1. 01	MAC WEST - NEW	0	1			Ö	1. 01
1. 02	NORTH ANNEX - NEW	0	0	C	•	0	1. 02
1.03	GARRETT CLINIC - NEW	0	0	C	/	0	1. 03
1.04	BUTLER - NEW	0	0	C	,	0	1. 04
1.05	MAC EAST - NEW	0	0	C	,	0	1. 05
1. 06 1. 07	GARRETT LAB - NEW MEDICAL ARTS - NEW	0		C		0	1. 06 1. 07
1.07	DAY SPRING - NEW	0				0	1. 07
2. 00	CAP REL COSTS-MVBLE EQUIP	0			9	Ö	2. 00
3.00	Total (sum of lines 1-2)	0	0	C	5, 208, 285	0	3. 00
			Sl	JMMARY OF CAPIT	AL		
	Cook Cooker December 1	1	1	T (	0+1	T-+-1 (2) (	
	Cost Center Description	Interest	Insurance (see		Other Capi tal -Relate	Total (2) (sum of cols. 9	
			Thisti dott ons)	Thisti dott ons)	d Costs (see	through 14)	
					instructions)	, ,	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS O			0	4 050 224	1 00
1. 00 1. 01	CAP REL COSTS-BLDG & FLXT MAC WEST - NEW	0	1			4, 958, 324 23, 501	1. 00 1. 01
1. 01	NORTH ANNEX - NEW	0				4, 584	1. 01
1. 03	GARRETT CLINIC - NEW	0	Ö	d		16, 587	1. 03
1.04	BUTLER - NEW	0	0	C	0	11, 914	1.04
1.05	MAC EAST - NEW	0	0	C		150, 192	1. 05
1.06	GARRETT LAB - NEW	0	0			0	1. 06
1.07	MEDICAL ARTS - NEW	0	0	C		43, 183	1. 07
1. 08 2. 00	DAY SPRING - NEW CAP REL COSTS-MVBLE EQUIP	0		C		0	1. 08 2. 00
3.00	Total (sum of lines 1-2)		1			_	
00		'	'	'	·	2, 200, 200	2.00

| Period: | Worksheet A-8 | From 10/01/2015 | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0045

NEW (chapter 2) 1.05   Investment income - MAC EAST - NEW   1.05   NEW (chapter 2)	o piii
Cost Center Description	
1.00   2.00   3.00   4.00   5.00	
1.00   2.00   3.00   4.00   5.00	
1.00   2.00   3.00   4.00   5.00	
1.00	
1.01 Investment income - MAC WEST - NEW (chapter 2) 1.02 Investment income - NORTH ANNEX - NEW (chapter 2) 1.03 Investment income - GARRETT (CLINIC - NEW (chapter 2)) 1.04 Investment income - BUTLER - NEW (chapter 2) 1.05 Investment income - MAC EAST - NEW (chapter 2) 1.06 Investment income - GARRETT (DINIC - NEW (chapter 2)) 1.07 Investment income - GARRETT (DINIC - NEW (CHAPTER - NEW (NEW (CHAPTER - NEW (NEW (CHAPTER - NEW (NEW (CHAPTER - NEW (NEW (NEW (CHAPTER - NEW (NEW (NEW (NEW (NEW (NEW (NEW (NEW	1.00
NEW (chapter 2)  1.02 Investment i ncome - NORTH ANNEX - NEW (chapter 2)  1.03 Investment i ncome - GARRETT (CLINIC - NEW (chapter 2))  1.04 Investment i ncome - BUTLER - NEW (chapter 2)  1.05 Investment i ncome - MAC EAST - NEW (chapter 2)  1.06 Investment i ncome - GARRETT (DMAC EAST - NEW (chapter 2))  1.07 Investment i ncome - GARRETT (DMAC EAST - NEW (chapter 2))  1.08 Investment i ncome - MEDICAL (Chapter 2)  1.09 Investment i ncome - DAY SPRING - NEW (chapter 2)  1.09 Investment i ncome - DAY SPRING - NEW (chapter 2)  1.09 Investment i ncome - CAP REL (COSTS-MVBLE EQUIP (chapter 2))	1. 01
ANNEX - NEW (chapter 2)  1.03	1.01
1.03   Investment income - GARRETT   OGARRETT CLINIC - NEW   1.03   1.04   Investment income - BUTLER - NEW (chapter 2)   OBUTLER - NEW (chapter 2)   1.05   Investment income - MAC EAST - NEW (chapter 2)   OMAC EAST - NEW   1.05   1.06   Investment income - GARRETT   OGARRETT LAB - NEW (chapter 2)   1.07   Investment income - MEDICAL   OMEDICAL ARTS - NEW   1.07   1.08   Investment income - DAY SPRING   ODAY SPRING - NEW   1.08   1.08   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09	1. 02
1. 04 Investment income - BUTLER - NEW (chapter 2) 1. 05 Investment income - MAC EAST - NEW (chapter 2) 1. 06 Investment income - GARRETT (chapter 2) 1. 07 Investment income - MEDICAL (chapter 2) 1. 08 Investment income - DAY SPRING (chapter 2) 1. 08 Investment income - DAY SPRING (chapter 2) 2. 00 Investment income - CAP REL (COSTS-MVBLE EQUIP (chapter 2)	1. 03
1.05   Investment income - MAC EAST - NEW (chapter 2) 1.06   Investment income - GARRETT   OGARRETT LAB - NEW (chapter 2) 1.07   Investment income - MEDICAL ARTS - NEW (chapter 2) 1.08   Investment income - DAY SPRING   ODAY SPRING - NEW (chapter 2) 1.08   Investment income - DAY SPRING   ODAY SPRING - NEW   1.08   1.09   Investment income - CAP REL   OCAP REL COSTS-MVBLE EQUIP   2.00   1.09   CAP REL COSTS-MVBLE EQUIP   CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - MEDICAL ARTS - NEW   1.07   1.09   Investment income - MEDICAL ARTS - NEW   1.07   1.09   Investment income - DAY SPRING   ODAY SPRING - NEW   1.08   1.09   Investment income - DAY SPRING   ODAY SPRING - NEW   1.08   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS-MVBLE EQUIP   2.00   1.09   Investment income - CAP REL COSTS	1. 04
NEW (chapter 2)  1.06 Investment income - GARRETT LAB - NEW (chapter 2)  1.07 Investment income - MEDICAL ARTS - NEW (chapter 2)  1.08 Investment income - DAY SPRING - NEW (chapter 2)  2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	1 05
LAB - NEW (chapter 2)  1.07 Investment i ncome - MEDICAL ARTS - NEW  1.07 ARTS - NEW (chapter 2)  1.08 Investment i ncome - DAY SPRING - NEW  2.00 Investment i ncome - CAP REL COSTS-MVBLE EQUIP  2.00 CAP REL COSTS-MVBLE EQUIP  2.00 CAP REL COSTS-MVBLE EQUIP	1. 05
1.07 Investment income - MEDICAL ARTS - NEW 1.07 ARTS - NEW (chapter 2) 1.08 Investment income - DAY SPRING - NEW 0DAY SPRING - NEW (chapter 2) 2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	1. 06
1.08 Investment income - DAY SPRING - NEW 1.08 - NEW (chapter 2) 2.00 Investment income - CAP REL COSTS-MVBLE EQUIP 2.00 CAP REL COSTS-MVBLE EQUIP 2.00	1. 07
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP 2.00 CAP REL COSTS-MVBLE EQUIP 2.00	1. 08
COSTS-MVBLE EQUIP (chapter 2)	2. 00
3.00   Investment income - other   0 0 0.00	2.00
(chapter 2)	3. 00
4.00 Trade, quantity, and time 0 0.00	4. 00
discounts (chapter 8) 5.00 Refunds and rebates of 0 0.00	5. 00
expenses (chapter 8) 6.00 Rental of provider space by 0 0.00	6. 00
suppliers (chapter 8)	
7.00 Tel ephone services (pay 0 0.00 stations excluded) (chapter	7. 00
21)	0.00
8.00   Television and radio service   0   0.00   0.00     0.00	8. 00
9.00   Parking Lot (chapter 21)   0   0.00   10.00   Provider-based physician   A-8-2   -971,571	9. 00 10. 00
adj ustment	
11.00   Sale of scrap, waste, etc.   0   0.00     0.00	11. 00
12.00 Related organization A-8-1 0	12. 00
transactions (chapter 10)  13.00 Laundry and Linen service B -896 LAUNDRY & LINEN SERVICE 8.00	13. 00
	14. 00 15. 00
and others	
16.00 Sale of medical and surgical 0 0.00 supplies to other than	16. 00
patients 17.00   Sale of drugs to other than B -201   DRUGS CHARGED TO PATIENTS 73.00	17. 00
pati ents pati ents	17.00
18.00 Sale of medical records and B -1,140 MEDICAL RECORDS & LIBRARY 16.00 abstracts	18. 00
19.00 Nursing school (tuition, fees, 0 0.00	19. 00
books, etc.) 20.00 Vending machines 0 0.00	20. 00
21.00 Income from imposition of one of interest, finance or penalty	21. 00
charges (chapter 21)	
22.00 Interest expense on Medicare 0 0.00 overpayments and borrowings to	22. 00
repay Medicare overpayments	
23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 therapy costs in excess of	23. 00
limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00	24. 00
therapy costs in excess of	24.00
limitation (chapter 14)   25.00   Utilization review -   0*** Cost Center Deleted ***   114.00	25. 00
physicians' compensation	
	26. 00
COSTS-BLDG & FIXT	Į

Peri od: 

				To	09/30/2016		
				Expense Classification on	Worksheet A	2/23/2017 4: 5	6 pm
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3. 00	4. 00	5. 00	
26. 01	Depreciation - MAC WEST - NEW	11.00		MAC WEST - NEW	1. 01	0.00	26. 01
26. 02	Depreciation - NORTH ANNEX -		0	NORTH ANNEX - NEW	1. 02	0	26. 02
	NEW						
26. 03	Depreciation - GARRETT CLINIC		0	GARRETT CLINIC - NEW	1. 03	0	26. 03
26. 04	- NEW Depreciation - BUTLER - NEW		0	BUTLER - NEW	1. 04	0	26. 04
26. 05	Depreciation - MAC EAST - NEW			MAC EAST - NEW	1. 04		26. 05
26. 06	Depreciation - GARRETT LAB -			GARRETT LAB - NEW	1.06		26. 06
	NEW		_				
26. 07	Depreciation - MEDICAL ARTS -		0	MEDICAL ARTS - NEW	1.07	0	26. 07
	NEW						
26. 08	Depreciation - DAY SPRING -		0	DAY SPRING - NEW	1. 08	0	26. 08
27. 00	NEW Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
27.00	COSTS-MVBLE EQUIP		0	CAI REE COSTS-WVBEE EQUIT	2.00		27.00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30.00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
	therapy costs in excess of						
20.00	limitation (chapter 14)		0	ADULTS & DEDLATRICS	20.00		20.00
30. 99	Hospice (non-distinct) (see instructions)		U	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	pathology costs in excess of						
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
22.00	Depreciation and Interest	, n	1/	EMPLOYEE DENEELTS DEDARTMENT	4 00		22.00
33. 00 33. 04	MI SC HUMAN RESOURCE REVENUE MI SCELLANEOUS I NCOME	B B		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00		33. 00 33. 04
33. 04	MISC. MAINTENANCE INCOME	В		OPERATION OF PLANT	7. 00		33. 04
33. 06	MISC. HOUSEKEEPING INCOME	В		HOUSEKEEPI NG	9. 00		33. 06
33. 07	DIABETES SERV. MISC. INCOME	В		DI ETARY	10. 00		33. 07
33. 09	MISC SUGERY REVENUE	В	-2, 955	OPERATING ROOM	50.00	0	33. 09
33. 10	MISC X-RAY REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00		33. 10
33. 11	MI SC LAB REVENUE	В		LABORATORY	60.00		33. 11
33. 12	MI SC. PT REVENUE	В		RESPIRATORY THERAPY	65.00		33. 12
33. 13 33. 14	MISC. ST REVENUE MISC. CARDIAC REHAB REVENUE	B B		PHYSI CAL THERAPY CARDI AC REHAB	66. 00 66. 01	0	33. 13 33. 14
33. 14	EMS CLASS TUITION	В		AMBULANCE SERVICES	95. 00		33. 14
33. 16	EMS COUNTY SUBSIDY	B		AMBULANCE SERVICES	95.00		33. 16
33. 17	MI SCELLANEOUS I NCOME	В		HOME HEALTH AGENCY	101.00	0	33. 17
33. 18	LOBBYING PORTION OF IHA & AHA	A	-6, 626	ADMINISTRATIVE & GENERAL	5.00	0	33. 18
	DUES						
33. 19	LOBBYING PORTION OF LAHHC DUES - HOS	A	-118	HOSPI CE	116. 00	0	33. 19
33. 20	LOBBYING PORTION OF LAHHC DUES	A	_274	HOME HEALTH AGENCY	101. 00	0	33. 20
33. 20	- HHA		-214	HOME HEALTH AGENOT	101.00		33. 20
33. 21	NON-ALLOWABLE MARKETING	A	-442, 897	ADMINISTRATIVE & GENERAL	5. 00	0	33. 21
33. 23	NON-ALLOWABLE MARKETING	A	-24, 826	PHYSICAL THERAPY	66.00	0	33. 23
33. 25	NON-ALLOWABLE MARKETING	A		CARDI AC REHAB	66. 01	0	33. 25
33. 26	NON-ALLOWABLE MARKETING	A		HOME HEALTH AGENCY	101.00		33. 26
33. 27	NON-ALLOWABLE MARKETING	A		HOSPI CE	116.00		33. 27
33. 28 33. 29	NON-ALLOWABLE MARKETING SNACK BAR	A B		PHARMACARE SNACK BAR	192. 02 10. 01	0	33. 28 33. 29
33. 30	FLOWER/GI FTS	A		NURSING ADMINISTRATION	13. 00		33. 29
33. 32	FLOWER/GIFTS	A		ADMINISTRATIVE & GENERAL	5. 00		33. 32
33. 34	CHRISTMAS PARTY & OPEN HOUSE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00		33. 34
33. 39	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00		33. 39
33. 40	HAF FEE	Α		ADMINISTRATIVE & GENERAL	5. 00		33. 40
33. 41	DONATION EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 41
50. 00	TOTAL (sum of lines 1 thru 49)		-3, 760, 353				50. 00
	(Transfer to Worksheet A, column 6, line 200.)						
	Teoramii o, Triie 200. j					I .	L

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

| Period: | Worksheet A-8-2 | From 10/01/2015 | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0045

					-	To 09/30/2016	Date/Time Pre 2/23/2017 4:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00		RADI OLOGY-DI AGNOSTI C	35, 188				0	1
2.00		OPERATING ROOM	798, 537			2077 100		
3.00		ADMINISTRATIVE & GENERAL	15, 000		,	1		
4.00		INTENSIVE CARE UNIT	50, 400					
5.00		ADULTS & PEDIATRICS	64, 000	•		20,,.00		0.00
6.00		ELECTROCARDI OLOGY	1, 200	•		2.1,000		0.00
7. 00		ADULTS & PEDIATRICS	1, 000			211, 500		,
8.00		INTENSIVE CARE UNIT	9, 225	•		2.1,000		
9.00		OPERATING ROOM	9, 630		0	211, 500	1	7.00
10.00	0. 00		0	1	45.000	0	0	1
200.00	Wkst. A Line #	Cost Center/Physician	984, 180 Unadj usted RCE		15, 000 Cost of		124 Physician Cost	
	WKST. A LINE #	I denti fi er		Unadjusted RCE			of Malpractice	
		r deriti i i ei	LIIIII	Li mi t	Continuing	Share of col.	Insurance	i
					Education	12	Trisui ance	
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	
1. 00		RADI OLOGY-DI AGNOSTI C	0				0	1.00
2.00		OPERATING ROOM	0	0	0	0	0	1
3.00	5. 00	ADMINISTRATIVE & GENERAL	12, 609	630	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4. 00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5. 00
6.00	69. 00	ELECTROCARDI OLOGY	0	0	0	0	0	6.00
7.00	30. 00	ADULTS & PEDIATRICS	0	0	0	0	0	7. 00
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	8. 00
9.00		OPERATING ROOM	0	0	0	0	0	7.00
10.00	0. 00		0	0	0	0	0	10.00
200.00			12, 609			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldentifier	Component	Limit	Di sal I owance			
			Share of col.					
	1, 00	2.00	14 15. 00	16. 00	17. 00	18.00		
1. 00		RADI OLOGY-DI AGNOSTI C	0					1.00
2.00		OPERATING ROOM	l o		0	1		2. 00
3. 00		ADMINISTRATIVE & GENERAL	l o	12, 609	2, 391	2, 391		3.00
4.00		INTENSIVE CARE UNIT	0	0		1		4. 00
5.00		ADULTS & PEDIATRICS	0	0	0			5. 00
6.00	69. 00	ELECTROCARDI OLOGY	0	0	0	1, 200		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,000		7. 00
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	9, 225		8. 00
9.00	50. 00	OPERATING ROOM	0	0	0	9, 630		9. 00
10.00	0. 00		0	0	0	0		10.00
200.00			0	12, 609	2, 391	971, 571		200.00

| Peri od: | Worksheet B | From 10/01/2015 | Part | | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0045

					T	o 09/30/2016	Date/Time Pre 2/23/2017 4:5	
			CAPITAL RELATED COSTS					
		Cost Center Description	Net Expenses	BLDG & FIXT	MAC WEST - NEW		GARRETT CLINIC	
			for Cost Allocation			NEW	- NEW	
			(from Wkst A					
			col. 7) 0	1.00	1. 01	1. 02	1. 03	
		AL SERVICE COST CENTERS					1, 00	
1. 00 1. 01	1	CAP REL COSTS-BLDG & FIXT MAC WEST - NEW	4, 958, 324	4, 958, 324 0				1. 00 1. 01
1. 01	1	NORTH ANNEX - NEW	23, 501 4, 584			4, 584		1. 01
1.03	1	GARRETT CLINIC - NEW	16, 587	O		0	16, 587	1. 03
1. 04 1. 05	1	BUTLER - NEW MAC EAST - NEW	11, 914 150, 192	0	0	0	0 0	1. 04 1. 05
1. 06		GARRETT LAB - NEW	0	Ö	ő	Ö	o o	1. 06
1.07	1	MEDICAL ARTS - NEW	43, 183	0	0	0	0	1.07
1. 08 2. 00		DAY SPRING - NEW  CAP REL COSTS-MVBLE EQUIP	0		0	0	0	1. 08 2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	671, 597	0	0	0	0	4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	8, 751, 568 2, 148, 558	1		0	0 0	5. 00 7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	23, 153	28, 868		0	0	8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	1, 177, 712 392, 233		•	0	0 0	9. 00 10. 00
10. 00	1	SNACK BAR	7, 017	1		0	0	10.00
11. 00		CAFETERI A	433, 443	1		0	0	11. 00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	997, 433 209, 396	1		0	0	13. 00 14. 00
15. 00	01500	PHARMACY	565, 518	1		Ö	o o	15. 00
16.00		MEDICAL RECORDS & LIBRARY	658, 391			0	0	16.00
17. 00		SOCIAL SERVICE  ENT ROUTINE SERVICE COST CENTERS	90, 262	3, 965	0	0	0	17. 00
30. 00	03000	ADULTS & PEDIATRICS	3, 289, 369	l .				
31. 00 43. 00	1	INTENSIVE CARE UNIT NURSERY	1, 492, 849 268, 125	1				31. 00 43. 00
	ANCI L	LARY SERVICE COST CENTERS						
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	2, 722, 034 528, 528	1		0	0	50. 00 52. 00
54. 00		RADI OLOGY-DI AGNOSTI C	3, 001, 380	1		0	0	54. 00
60.00	1	LABORATORY	3, 549, 226	ľ	1	0	3, 468	
60. 01 65. 00	1	BLOOD LABORATORY  RESPIRATORY THERAPY	679, 538	26, 402		0	0 0	60. 01 65. 00
66. 00	06600	PHYSI CAL THERAPY	1, 407, 087	126, 112	0	0	0	66. 00
66. 01 69. 00		CARDI AC REHAB ELECTROCARDI OLOGY	171, 382 77, 172	66, 368 0	1	0	0 1 0	66. 01 69. 00
70. 00		ELECTROENCEPHALOGRAPHY	79, 054			0	0	70.00
71. 00		MEDICAL SUPPLIES CHARGED TO PAT	1, 750, 867	0	0	0	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	1, 121, 414 3, 029, 577			0	0	72. 00 73. 00
	OUTPA	TIENT SERVICE COST CENTERS		-	_	-		
90. 00 91. 00		CLINIC EMERGENCY	66, 281 1, 741, 220			0		90. 00 91. 00
	09200	OBSERVATION BEDS (NON-DISTINCT	1, 741, 220	100,073				92.00
05.00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	1 404 520	42 401	Ι ο	0		05.00
	09910		1, 404, 530 0	42, 481 0		0	0	95. 00 99. 10
	10100	HOME HEALTH AGENCY	1, 148, 014	0	0	2, 595	0	101. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE			Ι			113. 00
	1	HOSPI CE	285, 526	O	0	281	0	116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49, 147, 739	4, 834, 993	5, 172	2, 876	3, 468	118. 00
190.00		IMBURSABLE COST CENTERS GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190. 00
191.00	19100	RESEARCH	0	0		0	0	191. 00
		PHYSICIANS PRIVATE OFFICES DEKALB MEDICAL SERVICES	0 8, 913, 383	0 123, 331	0 18, 329	0 1, 708	l e	192. 00 192. 01
	1	PHARMACARE	4, 383, 175		0,327	0		192. 02
		NONPALD WORKERS	0	0	0	0		193.00
		OTHER NONREIMBURSABLE COST CENT ADULT DAY CARE	0		0	0		194. 00 194. 01
194. 02	07952	FOUNDATI ON	13, 490	0	Ō	0		194. 02
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers			_	_	_	200. 00 201. 00
202.00	1	TOTAL (sum lines 118-201)	62, 457, 787	4, 958, 324	23, 501	4, 584	i e	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0045

Peri od: Worksheet B From 10/01/2015 Part I To 09/30/2016 Date/Time Prepared:

2/23/2017 4:56 pm

CAPITAL RELATED COSTS DAY SPRING -Cost Center Description BUTLER - NEW MAC EAST - NEW GARRETT LAB - MEDICAL ARTS -NFW NFW NFW 1.05 1.04 1.06 1.08 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 MAC WEST - NEW 1.01 00102 NORTH ANNEX - NEW 1.02 1 02 1.03 00103 GARRETT CLINIC - NEW 1.03 00104 BUTLER - NEW 1.04 11, 914 1.04 00105 MAC EAST - NEW 150, 192 1.05 1.05 00106 GARRETT LAB - NEW 1.06 0 1.06 1.07 00107 MEDICAL ARTS - NEW 0 43, 183 1.07 00108 DAY SPRING - NEW 0 1.08 C 1.08 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 0 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 0000000000 20. 112 5.00 7.00 00700 OPERATION OF PLANT 0 7.00 3.424 0 44.640 00800 LAUNDRY & LINEN SERVICE 0 8.00 0 0 8.00 9.00 00900 HOUSEKEEPI NG 305 0 0 9.00 01000 DI ETARY 10.00 817 0 0 10.00 01001 SNACK BAR 0 10 01 0 10 01 0 11.00 01100 CAFETERI A C 0 11.00 01300 NURSING ADMINISTRATION 0 0 0 13.00 13.00 C 0 01400 CENTRAL SERVICES & SUPPLY 14.00 0 0 14.00 0 0 01500 PHARMACY 15 00 15 00 0 0 0 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 138 0 0 16.00 01700 SOCIAL SERVICE 17.00 0 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 31.00 31.00 04300 NURSERY 43.00 0 0 o 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 843 0 0 0 60 00 60.01 06001 BLOOD LABORATORY 0 0 0 0 60.01 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 0 0 0 66, 00 66,00 0 06601 CARDI AC REHAB 0 66.01 0 0 66.01 69.00 06900 ELECTROCARDI OLOGY 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 71.00 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 r 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 0 0 0 0 09100 EMERGENCY 91.00 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 95 00 09500 AMBULANCE SERVICES 0 Ω 0 0 Ω 99. 10 09910 CORF 0 0 0 0 99.10 101.00 10100 HOME HEALTH AGENCY 0 Ω 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 843 67, 012 0 3, 424 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 0 0 0 190.00 0 191. 00 19100 RESEARCH 0 191.00 0 0 0 0 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 192. 01 19201 DEKALB MEDICAL SERVICES 0 39, 759 0 192. 01 11,071 83, 180 192. 02 19202 PHARMACARE 0 192. 02 193. 00 19300 NONPALD WORKERS 0 193.00 0 0 0 0 194. 00 07950 OTHER NONREIMBURSABLE COST CENT 0 0 0 0 194.00 Ω 0 194. 01 194. 01 07951 ADULT DAY CARE 0 0 C 0 194. 02 07952 FOUNDATI ON 0 0 0 0 194. 02 200.00 Cross Foot Adjustments 200. 00 201 00 0 0 201.00 Negative Cost Centers 0 202.00 TOTAL (sum lines 118-201) 11, 914 150, 192 0 43, 183 0 202.00

| Peri od: | Worksheet B | From 10/01/2015 | Part | | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0045

					Т	o 09/30/2016	Date/Time Pre 2/23/2017 4:5	
			CAPITAL				2/23/2017 4.3	O pili
			RELATED COSTS					
		Cost Center Description	MVBLE EQUIP	EMPLOYEE	Subtotal	ADMI NI STRATI VE		
				BENEFITS		& GENERAL	PLANT	
			2.00	DEPARTMENT 4. 00	4A	5. 00	7. 00	
	GENER	AL SERVICE COST CENTERS	2.00	4.00	1 4/1	3.00	7.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1. 01
1.02	1	NORTH ANNEX - NEW						1. 02
1.03		GARRETT CLINIC - NEW						1. 03
1. 04 1. 05		BUTLER - NEW MAC EAST - NEW						1. 04 1. 05
1.05	1	GARRETT LAB - NEW						1.05
1. 07		MEDICAL ARTS - NEW						1. 07
1.08		DAY SPRING - NEW						1. 08
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0					2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	671, 597				4. 00
5.00	1	ADMINISTRATIVE & GENERAL	0	89, 770			4 000 7/0	5. 00
7. 00 8. 00	1	OPERATION OF PLANT	0	14, 279 401			4, 898, 769	1
9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	16, 937			37, 804 62, 849	1
10.00	1	DI ETARY	0	5, 190			38, 184	1
10. 01		SNACK BAR	o	570	·		0	1
11.00	01100	CAFETERI A	0	8, 682	499, 112	89, 356	74, 627	11. 00
13.00		NURSING ADMINISTRATION	0	20, 444			33, 561	13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	0	2, 219			39, 862	1
15. 00	1	PHARMACY	0	12, 798			36, 664	
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0	12, 381 1, 779			97, 487 5, 193	
17.00		I ENT ROUTINE SERVICE COST CENTERS	<u> </u>	1, 779	90,000	17, 100	5, 193	17.00
30. 00		ADULTS & PEDIATRICS	0	59, 160	3, 632, 039	650, 240	371, 266	30. 00
31.00	1	INTENSIVE CARE UNIT	0	24, 018			157, 644	
43.00		NURSERY	0	4, 285	293, 977	52, 630	28, 242	43. 00
		LARY SERVICE COST CENTERS	T -1		T	I		
50.00	1	OPERATING ROOM	0	39, 352			561, 711	
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0	8, 479 43, 216			436, 805 294, 929	
60.00		LABORATORY		31, 911			168, 599	
60. 01		BLOOD LABORATORY	o o	01, 711		0	0	1
65.00	06500	RESPI RATORY THERAPY	0	13, 074	719, 014	128, 724	34, 575	65. 00
66. 00	1	PHYSI CAL THERAPY	0	6, 806	1, 540, 005		165, 148	1
66. 01		CARDI AC REHAB	0	3, 627			86, 911	
69.00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	1, 487			0	
70. 00 71. 00		MEDICAL SUPPLIES CHARGED TO PAT	0	1, 221 0			0	
71.00		IMPL. DEV. CHARGED TO PATIENTS	0	0			0	
73. 00		DRUGS CHARGED TO PATIENTS	o	0			0	1
	OUTPA	TIENT SERVICE COST CENTERS						
90.00		CLI NI C	0	1, 455			0	
		EMERGENCY	0	31, 812	1, 959, 105	350, 737	243, 669	
92.00		OBSERVATION BEDS (NON-DISTINCT REIMBURSABLE COST CENTERS						92.00
95 00		AMBULANCE SERVICES	0	28, 627	1, 475, 638	264, 182	55 630	95. 00
	09910		o	0		0	0	1
		HOME HEALTH AGENCY	0	18, 440	1, 169, 049	209, 294	87, 766	101. 00
		AL PURPOSE COST CENTERS	, ,					
	1	I NTEREST EXPENSE		4 000		F4 F00	0.400	113. 00
		HOSPI CE	0	1, 980				116. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS	<u> </u>	504, 400	48, 690, 045	7, 019, 045	3, 128, 625	] 118.00
190.00		GIFT FLOWER COFFEE SHOP & CAN	0	0		O	0	190. 00
		RESEARCH	o	0	d	o		191. 00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	C	o o	0	192. 00
		DEKALB MEDICAL SERVICES	0	155, 890		1 1	1, 770, 144	
		PHARMACARE	0	11, 079	4, 394, 254	786, 699	_	192. 02
		NONPAID WORKERS OTHER NONREIMBURSABLE COST CENT	0	0				193. 00 194. 00
		ADULT DAY CARE		0	1			194. 00
		FOUNDATION		228		2, 456		194. 01
200.00		Cross Foot Adjustments			0	_, .55		200. 00
201.00	1	Negative Cost Centers	0	0	C	ol		201. 00
202.00	)	TOTAL (sum lines 118-201)	0	671, 597	62, 457, 787	9, 483, 861	4, 898, 769	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2015 Part I
To 09/30/2016 Date/Time Prepared: 2/23/2017 4:56 pm

				''	09/30/2010	2/23/2017 4:5	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	
		LINEN SERVICE 8.00	9. 00	10.00	10. 01	11. 00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	10.00	10.01	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MAC WEST - NEW						1. 01
1. 02	00102 NORTH ANNEX - NEW						1. 02
1.03	00103 GARRETT CLINIC - NEW						1.03
1.04	00104 BUTLER - NEW						1. 04
1. 05 1. 06	00105 MAC EAST - NEW 00106 GARRETT LAB - NEW						1. 05 1. 06
1. 00	00100 GARRETT EAS - NEW						1.00
1. 08	00108 DAY SPRING - NEW						1. 08
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	99, 611					8. 00
9.00	00900 HOUSEKEEPI NG	8, 920	1, 535, 074				9.00
10.00	01000 DI ETARY	672	12, 216		0.045		10.00
10. 01 11. 00	01001 SNACK BAR 01100 CAFETERIA	0	23, 876	0	8, 945 8, 945	695, 916	10. 01 11. 00
13. 00	01300 NURSING ADMINISTRATION		10, 737	0	0, 745	21, 756	1
14. 00	01400 CENTRAL SERVICES & SUPPLY		12, 753	0	0	5, 359	1
15. 00	01500 PHARMACY	o	11, 730	o o	o	11, 818	
16. 00	01600 MEDICAL RECORDS & LIBRARY	o	31, 189	0	0	25, 695	1
17.00	01700 SOCIAL SERVICE	0	1, 661	0	0	2, 040	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	28, 698	118, 780		0		1
31.00	03100   NTENSI VE CARE UNI T	8, 597	50, 435		0		1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	9, 036	0	0	6, 719	43. 00
50. 00	05000 OPERATING ROOM	14, 038	179, 710	0	0	52, 991	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	14, 030	139, 748		Ö	13, 318	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	11, 619	94, 357	0	O	57, 510	1
60.00	06000 LABORATORY	o	53, 940	0	0	53, 790	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	0	11, 062	0	0	19, 177	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 989	52, 836	0	0	11, 118	1
66. 01	06601 CARDI AC REHAB	399	27, 806		0	6, 719	1
69.00	06900 ELECTROCARDI OLOGY	701	0	0	0	2, 800	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PAT	701	0	0	0	1, 880 0	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	0	Ö	0	
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			- 1		
90.00	09000 CLI NI C	462	0	0	0	1, 240	90.00
91. 00	09100 EMERGENCY	17, 863	77, 958	0	0	45, 712	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT						92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	2.02/	17 700		ما	10.051	05 00
95.00	09500 AMBULANCE SERVI CES 09910 CORF	3, 826	17, 798	0	0	49, 951	95. 00 99. 10
	10100 HOME HEALTH AGENCY	0	28, 079	] 0 0	0		101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	20, 017		0	21,413	101.00
113. 00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	61	3, 039	0	0	2, 060	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	97, 845	968, 746	549, 172	8, 945	543, 746	118. 00
	NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,					
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CLANS PRI VATE OFFI CES	1 7//	U E// 220	0	0		192. 00
	19201 DEKALB MEDICAL SERVICES   19202 PHARMACARE	1, 766	566, 328	0	0	135, 453	192. 01
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 OTHER NONREIMBURSABLE COST CENT		0	0	0		194. 00
	07951 ADULT DAY CARE		0	ا م	o o		194. 01
	207952 FOUNDATION		0	Ö	o		194. 02
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	99, 611	1, 535, 074	549, 172	8, 945	695, 916	202.00

Provider CCN: 15-0045

			10	09/30/2016	2/23/2017 4:50	
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	RECORDS &	SOCIAL SERVICE	у ріп
	13.00	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	17. 00	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	17.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01   00101 MAC WEST - NEW						1. 01
1.02   00102   NORTH ANNEX - NEW						1. 02
1.03 O0103 GARRETT CLINIC - NEW						1. 03
1.04   00104   BUTLER - NEW						1. 04
1.05   00105   MAC EAST - NEW						1. 05
1.06   00106   GARRETT LAB - NEW						1. 06
1.07   00107   MEDICAL ARTS - NEW						1. 07
1. 08   00108 DAY SPRING - NEW						1. 08
2. 00   00200   CAP REL COSTS-MVBLE EQUIP						2.00
4.00   O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00   O0500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7.00   00700   OPERATION OF PLANT						7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10. 00
10. 01   01001   SNACK BAR						10. 01
11. 00   01100   CAFETERI A						11. 00
13.00 01300 NURSING ADMINISTRATION	1, 296, 378					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	24, 292	367, 656				14.00
15. 00 01500 PHARMACY	0	0	775, 074			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	1, 026, 248		16. 00
17. 00 01700 SOCIAL SERVICE	9, 228	0	0	0	131, 316	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		_1	_1			
30. 00   03000   ADULTS & PEDI ATRI CS	402, 702	0	0	102, 562		30.00
31. 00   03100   NTENSI VE CARE UNI T	162, 297	0	0	37, 696		31.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	30, 508	0	0	6, 517	0	43. 00
50. 00   05000   OPERATING ROOM	240, 309	ol	0	144, 806	0	50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	60, 367	o	0	12, 895	0	52. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	00,007	Ö	0	190, 970	0	54. 00
60. 00   06000   LABORATORY	21, 307	0	0	146, 341	Ö	60. 00
60. 01   06001   BLOOD   LABORATORY	0	o	Ö	0	Ö	60. 01
65. 00 06500 RESPIRATORY THERAPY	О	o	0	35, 985	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	O	o	0	40, 134	0	66. 00
66. 01   06601   CARDI AC REHAB	0	0	0	3, 084	0	66. 01
69. 00   06900   ELECTROCARDI OLOGY	0	0	0	10, 134	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	7, 778	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	367, 656	0	71, 660	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	775, 074	0	0	73. 00
90. 00   09000   CLINIC	5, 636	O	0	1, 235	0	90. 00
91. 00   09100   EMERGENCY	207, 281	o	0	110, 715	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	207, 201	ĭ	Ö	110, 713	١	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
99. 10   09910   CORF	0	O	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	123, 084	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	9, 367	0	0	4, 564		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	1, 296, 378	367, 656	775, 074	927, 076	131, 316	118. 00
NONREI MBURSABLE COST CENTERS		ما		ما		100.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 191.00 19100 RESEARCH	0	0	0	0		190. 00 191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		191.00
192. 00 19200 PHTSICIANS PRIVATE OFFICES  192. 01 19201 DEKALB MEDICAL SERVICES		0	0	99, 172		192. 00
192. 02 19202 PHARMACARE		0	0	77, 172		192. 01
193. 00 19300 NONPALD WORKERS		n	0	n		193. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENT		ol	0	o		194. 00
194. 01 07951 ADULT DAY CARE		ol	Ö	o		194. 01
194. 02 07952 FOUNDATI ON	0	o	O	o		194. 02
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	o		201. 00
202.00 TOTAL (sum lines 118-201)	1, 296, 378	367, 656	775, 074	1, 026, 248	131, 316	202. 00

| Peri od: | Worksheet B | From 10/01/2015 | Part | | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0045

				To 09/30/2016	Date/Ti me Prepared: 2/23/2017 4:56 pm
Cost Center Description	Subtotal	Intern &	Total		272372017 4.30 piii
		Residents Cost & Post			
		Stepdown			
	24.00	Adjustments 25.00	26. 00		
GENERAL SERVICE COST CENTERS	24.00	23.00	20.00		
1.00 00100 CAP REL COSTS-BLDG & FLXT					1.00
1. 01   00101   MAC WEST - NEW 1. 02   00102   NORTH ANNEX - NEW					1. 01
1. 03   00102   NORTH ANNEX - NEW					1. 02
1. 04   00104   BUTLER - NEW					1. 04
1.05   00105 MAC EAST - NEW					1. 05
1. 06   00106   GARRETT LAB - NEW					1.06
1. 07   00107   MEDI CAL ARTS - NEW 1. 08   00108   DAY SPRI NG - NEW					1. 07
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5. 00
7.00   00700   OPERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
10. 01   01001   SNACK BAR					10. 01
11. 00   01100   CAFETERI A					11.00
13. 00   01300   NURSI NG   ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY					13. 00 14. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00 01700 SOCI AL SERVI CE					17. 00
30.00 O3000 ADULTS & PEDIATRICS	5, 991, 773	3 0	5, 991, 77	73	30.00
31. 00   03100   INTENSI VE CARE UNI T	2, 466, 653	1	2, 466, 65		31.00
43. 00 04300 NURSERY	427, 629		427, 62		43. 00
ANCILLARY SERVICE COST CENTERS	4 055 050	J al	4 055 05		50.00
50.00   05000   OPERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	4, 955, 052 1, 689, 554		4, 955, 05 1, 689, 55		50. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 504, 589		4, 504, 58		54. 00
60. 00   06000   LABORATORY	4, 790, 737	7 O	4, 790, 73	37	60. 00
60. 01   06001   BLOOD LABORATORY	040 525		040 5	0	60. 01
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	948, 537 2, 086, 936	1	948, 53 2, 086, 93		65. 00 66. 00
66. 01   06601   CARDI AC REHAB	409, 509		409, 50		66. 01
69. 00 06900 ELECTROCARDI OLOGY	105, 675	1	105, 67		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	105, 006		105, 00		70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PAT 72.00   07200   MPL. DEV. CHARGED TO PATIENTS	2, 503, 639 1, 322, 180	1	2, 503, 63 1, 322, 18		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 347, 033		4, 347, 03		73. 00
OUTPATIENT SERVICE COST CENTERS			.,		
90. 00   09000   CLI NI C	88, 436		88, 43		90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS   (NON-DISTINCT	3, 013, 040	0 0	3, 013, 04	10	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS		<u> </u>			72.00
95. 00 09500 AMBULANCE SERVICES	1, 867, 025	0	1, 867, 02	25	95. 00
99. 10 09910 CORF	1 (11 71	0	4 (44 7	0	99. 10
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 644, 747	7 0	1, 644, 74	+/	101. 00
113. 00 11300   INTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE	367, 899		367, 89	99	116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	43, 635, 649	9 0	43, 635, 64	19	118. 00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN					190. 00
191. 00 19100 RESEARCH		ol ol		0	191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES		ol ol		0	192. 00
192. 01 19201 DEKALB MEDI CAL SERVI CES	13, 608, 294		13, 608, 29		192. 01
192. 02 19202 PHARMACARE 193. 00 19300 NONPALD WORKERS	5, 197, 430		5, 197, 43	30	192. 02 193. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENT		ol ol		o	194. 00
194.01 07951 ADULT DAY CARE		ol ol		0	194. 01
194. 02 07952 FOUNDATI ON	16, 414	IJ 이	16, 41	14	194. 02
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers				O	200. 00 201. 00
202.00   TOTAL (sum lines 118-201)	62, 457, 787	7 0	62, 457, 78	37	202. 00
, , , , , , , , , , , , , , , , , , , ,	1	, 91	,	1	1-2

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0045

						0 09/30/2016	Date/lime Pre 2/23/2017 4:5	
					CAPITAL RE	LATED COSTS		
		Cost Center Description	Directly	BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX -	GARRETT CLINIC	
			Assigned New			NEW	- NEW	
			Capi tal Rel ated Costs					
			0	1. 00	1. 01	1. 02	1. 03	
		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT			I			1. 00
		MAC WEST - NEW						1. 01
		NORTH ANNEX - NEW						1. 02
	1	GARRETT CLINIC - NEW BUTLER - NEW						1. 03 1. 04
1. 05	00105	MAC EAST - NEW						1. 05
		GARRETT LAB - NEW						1.06
	1	MEDICAL ARTS - NEW DAY SPRING - NEW						1. 07 1. 08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2. 00
		EMPLOYEE BENEFITS DEPARTMENT	0	622 411	0	0	0	4. 00 E. 00
	1	ADMINISTRATIVE & GENERAL OPERATION OF PLANT		622, 411 1, 938, 845		0		5. 00 7. 00
8. 00	00800	LAUNDRY & LINEN SERVICE	0	28, 868	0		0	8. 00
	1	HOUSEKEEPI NG DI ETARY	0	46, 156 24, 226	•	0	0	9. 00 10. 00
	1	SNACK BAR	0	24, 220		0	0	10.00
	1	CAFETERI A	O	56, 987		_	0	11. 00
		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	25, 629 30, 440		0	0	13. 00 14. 00
		PHARMACY	0	27, 998		0	Ö	15. 00
	1	MEDICAL RECORDS & LIBRARY	0	67, 577			0	16.00
17. 00		SOCIAL SERVICE ENT ROUTINE SERVICE COST CENTERS	0	3, 965	0	0	0	17. 00
	03000	ADULTS & PEDI ATRI CS	0	283, 510	0		•	30. 00
		INTENSIVE CARE UNIT	0	120, 382			0	31.00
		NURSERY _ARY SERVICE COST CENTERS	l o	21, 567		0	0	43. 00
50. 00	05000	OPERATING ROOM	0	428, 940			0	50. 00
	1	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0	333, 558 225, 217			0	52. 00 54. 00
		LABORATORY	0	101, 281		0	3, 468	60.00
		BLOOD LABORATORY	0	0		0	0	60. 01
		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	26, 402 126, 112	1		0	65. 00 66. 00
		CARDI AC REHAB	o o	66, 368		_	ő	66. 01
	1	ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PAT		0		0	0	70. 00 71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	O	0			0	72. 00
		DRUGS CHARGED TO PATIENTS FIENT SERVICE COST CENTERS	0	0	0	0	0	73. 00
		CLINIC	0	0	0	0	0	90. 00
		EMERGENCY	0	186, 073	0	0	0	
		OBSERVATION BEDS (NON-DISTINCT REIMBURSABLE COST CENTERS						92. 00
95. 00	09500	AMBULANCE SERVICES	0	42, 481			0	95. 00
	09910		0	0			0	
		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	l ol	0	1 0	2, 595		101. 00
		INTEREST EXPENSE		_			_	113. 00
116. 00 118. 00		HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0 0	0 4, 834, 993	0 5, 172			116. 00 118. 00
		MBURSABLE COST CENTERS	0	4,004,770	3, 172	2,070	3, 400	110.00
		GIFT FLOWER COFFEE SHOP & CAN	0	0			l	190. 00
	1	RESEARCH PHYSICIANS PRIVATE OFFICES	0	0		0		191. 00 192. 00
192. 01	19201	DEKALB MEDICAL SERVICES	o	123, 331	18, 329	1, 708	13, 119	192. 01
		PHARMACARE NONDALD WORKERS	0	0	0	0		192. 02
		NONPALD WORKERS OTHER NONREIMBURSABLE COST CENT		0		0		193. 00 194. 00
194. 01	07951	ADULT DAY CARE	0	0	0	0	0	194. 01
194. 02 200. 00		FOUNDATION Cross Foot Adjustments	0	0	0	0	0	194. 02 200. 00
200.00		Negative Cost Centers		0	0	О		201. 00
202. 00		TOTAL (sum lines 118-201)	o	4, 958, 324	23, 501	4, 584	16, 587	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0045

Peri od: Worksheet B From 10/01/2015 Part II To 09/30/2016 Date/Time Prepared:

2/23/2017 4:56 pm CAPITAL RELATED COSTS DAY SPRING -Cost Center Description BUTLER - NEW MAC EAST - NEW GARRETT LAB - MEDICAL ARTS -NFW NFW NFW 1.04 1.05 1.06 1.08 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 MAC WEST - NEW 1.01 00102 NORTH ANNEX - NEW 1.02 1 02 1.03 00103 GARRETT CLINIC - NEW 1.03 00104 BUTLER - NEW 1.04 1.04 00105 MAC EAST - NEW 1.05 1.05 00106 GARRETT LAB - NEW 1.06 1.06 1.07 00107 MEDICAL ARTS - NEW 1.07 00108 DAY SPRING - NEW 1.08 1.08 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 20, 112 5.00 7.00 00700 OPERATION OF PLANT 000000000 0 7.00 3.424 0 44.640 00800 LAUNDRY & LINEN SERVICE 0 8.00 0 0 8.00 9.00 00900 HOUSEKEEPI NG 305 0 0 9.00 01000 DI ETARY 0 10.00 817 0 0 10.00 01001 SNACK BAR 0 10 01 0 10 01 0 11.00 01100 CAFETERI A C 0 11.00 01300 NURSING ADMINISTRATION 0 0 0 13.00 13.00 0 0 01400 CENTRAL SERVICES & SUPPLY 0 14.00 0 14.00 0 01500 PHARMACY 0 15 00 15 00 0 0 0 0 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 138 0 16.00 01700 SOCIAL SERVICE 17.00 0 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 31.00 31.00 04300 NURSERY 43.00 0 0 o 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 843 0 0 60 00 0 60.01 06001 BLOOD LABORATORY 0 0 0 0 60.01 06500 RESPIRATORY THERAPY 0 65.00 65.00 66, 00 06600 PHYSI CAL THERAPY 0 0 0 0 66, 00 0 06601 CARDI AC REHAB 0 66.01 0 0 66.01 69.00 06900 ELECTROCARDI OLOGY 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 r 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 0 0 0 0 09100 EMERGENCY 91.00 0 C 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95.00 09500 AMBULANCE SERVICES 0 Ω 0 0 Ω 99. 10 09910 CORF 0 0 0 0 99.10 101.00 10100 HOME HEALTH AGENCY 0 0 Ω 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 843 67, 012 0 3, 424 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 0 0 0 190.00 0 191. 00 19100 RESEARCH 0 191.00 0 0 0 0 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 0 192. 01 19201 DEKALB MEDICAL SERVICES 0 39, 759 0 192. 01 11,071 83, 180 192. 02 19202 PHARMACARE 0 192. 02 193. 00 19300 NONPALD WORKERS 0 193.00 0 0 0 0 194. 00 07950 OTHER NONREIMBURSABLE COST CENT 0 0 0 0 194.00 Ω 0 194. 01 07951 ADULT DAY CARE 0 194. 01 0 C 0 194. 02 07952 FOUNDATI ON 0 0 0 0 194. 02 200.00 Cross Foot Adjustments 200. 00 201 00 0 0 201.00 Negative Cost Centers 0

11, 914

150, 192

0

43, 183

0 202.00

TOTAL (sum lines 118-201)

202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0045

					'	0 09/30/2016	2/23/2017 4:5	
			CAPI TAL				272372017 4.3	O pili
			RELATED COSTS					
		Cost Center Description	MVBLE EQUIP	Subtotal	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	
		·			BENEFITS	& GENERAL	PLANT	
					DEPARTMENT			
			2. 00	2A	4. 00	5. 00	7. 00	
		AL SERVICE COST CENTERS			T			
1.00	1	CAP REL COSTS-BLDG & FIXT						1.00
1.01	1	MAC WEST - NEW						1. 01
1.02		NORTH ANNEX - NEW						1. 02
1.03	1	GARRETT CLINIC - NEW						1.03
1. 04 1. 05	1	BUTLER - NEW MAC EAST - NEW						1. 04 1. 05
1.05	1	GARRETT LAB - NEW						1.05
1. 07		MEDICAL ARTS - NEW						1. 00
1.07	1	DAY SPRING - NEW						1. 08
2.00	1	CAP REL COSTS-MVBLE EQUIP						2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	0	(			4. 00
5. 00	1	ADMINISTRATIVE & GENERAL	o	642, 523				5. 00
7.00		OPERATION OF PLANT	0	1, 992, 081			2, 042, 476	•
8.00	1	LAUNDRY & LINEN SERVICE	O	28, 868		636	15, 762	•
9.00	00900	HOUSEKEEPI NG	O	46, 461	(	15, 053	26, 204	9. 00
10.00	01000	DIETARY	O	25, 043	(	5, 124	15, 920	10.00
10. 01	01001	SNACK BAR	0	0	C	92	0	10. 01
11. 00		CAFETERI A	0	56, 987	(	6, 054	31, 115	11. 00
13.00	1	NURSING ADMINISTRATION	0	25, 629	C	12, 657	13, 993	
14.00		CENTRAL SERVICES & SUPPLY	0	30, 440		, , , , ,	16, 620	14. 00
15. 00		PHARMACY	0	27, 998	•		15, 287	15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	68, 715			40, 646	1
17. 00	-	SOCIAL SERVICE	0	3, 965	(	1, 164	2, 165	17. 00
		I ENT ROUTI NE SERVI CE COST CENTERS		202 512			454 704	
30.00		ADULTS & PEDIATRICS	0	283, 510			154, 794	1
31.00		INTENSIVE CARE UNIT	0	120, 382			65, 727	31.00
43. 00		NURSERY LARY SERVICE COST CENTERS	0	21, 567	(	3, 566	11, 775	43. 00
50. 00		OPERATING ROOM		428, 940		38, 695	234, 198	50.00
52. 00	1	DELIVERY ROOM & LABOR ROOM		333, 558			182, 120	1
54. 00	1	RADI OLOGY-DI AGNOSTI C		225, 217			122, 967	1
60.00	1	LABORATORY		105, 592			70, 295	1
60. 01		BLOOD LABORATORY	0	0			0	60. 01
65. 00	1	RESPI RATORY THERAPY	0	26, 402			14, 415	•
66.00	06600	PHYSI CAL THERAPY	O	126, 112	(		68, 856	66. 00
66. 01	06601	CARDI AC REHAB	0	66, 368	C	2, 928	36, 237	66. 01
69.00	06900	ELECTROCARDI OLOGY	0	0	C	954	0	69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	C	974	0	70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PAT	0	0	(	21, 236	0	71. 00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	0	(	36, 746	0	73. 00
		TIENT SERVICE COST CENTERS						
90.00		CLINIC EMERGENCY	0	0				90.00
			U	186, 073		23, 762	101, 594	1
92. 00		OBSERVATION BEDS (NON-DISTINCT REIMBURSABLE COST CENTERS		0				92. 00
95. 00		AMBULANCE SERVICES	0	42, 481		17, 898	23, 194	95. 00
99. 10	09910			4 <u>2,</u> 401			23, 174	99. 10
		HOME HEALTH AGENCY	0	2, 595			_	101. 00
		AL PURPOSE COST CENTERS	-1	=1 = 1 =			201212	
113.00		INTEREST EXPENSE						113. 00
		HOSPI CE	o	281		3, 491	3, 960	116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4, 917, 788	(	475, 533	1, 304, 437	118. 00
		MBURSABLE COST CENTERS						
	1	GIFT FLOWER COFFEE SHOP & CAN	0	0	(	0		190. 00
		RESEARCH	0	0	C	0		191. 00
		PHYSICIANS PRIVATE OFFICES	0	0	C	0		192. 00
		DEKALB MEDI CAL SERVI CES	0	290, 497	(	113, 526	738, 039	
	1	PHARMACARE	0	0		53, 298		192. 02
		NONPALD WORKERS		0				193.00
		OTHER NONREIMBURSABLE COST CENT		0				194. 00 194. 01
		ADULT DAY CARE FOUNDATION		0		122		194. 01
200.00		Cross Foot Adjustments		0		166		200. 00
200.00	1	Negative Cost Centers		0	,	ا ا	0	200.00
201.00	1	TOTAL (sum lines 118-201)		5, 208, 285		642, 523		
_02.00	.1	1.1 (34 1.1.03 110 201)	1 9	5, 200, 200	,	., 572, 525	2, 5, 2, 470	,_02. 00

| Peri od: | Worksheet B | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0045

				To	09/30/2016	Date/Time Pre 2/23/2017 4:5	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	) piii
		LINEN SERVICE	0.00	10.00	10.01	11 00	
GENER	RAL SERVICE COST CENTERS	8. 00	9. 00	10.00	10. 01	11. 00	
	CAP REL COSTS-BLDG & FIXT						1. 00
	MAC WEST - NEW						1. 01
1	NORTH ANNEX - NEW						1. 02
	3 GARRETT CLINIC - NEW 1 BUTLER - NEW						1. 03 1. 04
	MAC EAST - NEW						1. 04
	GARRETT LAB - NEW						1. 06
	MEDICAL ARTS - NEW						1. 07
	B DAY SPRING - NEW						1. 08
4	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
	ADMINISTRATIVE & GENERAL						5. 00
4	OPERATION OF PLANT						7. 00
	LAUNDRY & LINEN SERVICE	45, 266					8. 00
	HOUSEKEEPI NG DI ETARY	4, 053 305	91, 771 730	1			9. 00 10. 00
	SNACK BAR	0	730		92		10.00
	CAFETERIA	0	1, 427		92	95, 675	
	NURSING ADMINISTRATION	0	642		o	2, 991	
	CENTRAL SERVICES & SUPPLY	0	762	1	0	737	1
	PHARMACY MEDICAL RECORDS & LIBRARY	0	701 1, 865	0	0	1, 625 3, 533	1
1	SOCIAL SERVICE	0	99	l	0	280	1
	TIENT ROUTINE SERVICE COST CENTERS			-	-1		
	ADULTS & PEDIATRICS	13, 041	7, 101		0	-	1
1	INTENSIVE CARE UNIT	3, 907	3, 015 540		0	4, 921 924	1
	NURSERY LARY SERVICE COST CENTERS	U	540	<u> </u>	<u> </u>	924	43.00
	OPERATING ROOM	6, 379	10, 744	0	0	7, 285	50. 00
	DELIVERY ROOM & LABOR ROOM	0	8, 355	l	o	1, 831	1
	RADI OLOGY-DI AGNOSTI C	5, 280	5, 641	l	0	7, 906	1
	LABORATORY   BLOOD LABORATORY	0	3, 225 0		0	7, 395 0	1
1	RESPI RATORY THERAPY	0	661	0	ő	2, 636	
	PHYSI CAL THERAPY	904	3, 159	0	o	1, 529	
4	CARDI AC REHAB	181	1, 662		0	924	1
	ELECTROCARDI OLOGY   ELECTROENCEPHALOGRAPHY	0 319	0	0	0	385 258	1
4	MEDICAL SUPPLIES CHARGED TO PAT	319	0	0	0	230	1
	IMPL. DEV. CHARGED TO PATIENTS	0	0		Ö	0	
	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	ATIENT SERVICE COST CENTERS	210	0		ام	170	00.00
	CLINIC EMERGENCY	210 8, 118	0 4, 661		0	170 6, 284	
1	OBSERVATION BEDS (NON-DISTINCT	0,110	4,001		Ĭ	0, 204	92. 00
OTHER	R REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES	1, 738			0		95.00
99. 10 09910	O HOME HEALTH AGENCY	0	0 1, 679		0		99. 10 101. 00
	AL PURPOSE COST CENTERS	0	1,077	]	<u> </u>	3,777	1101.00
	INTEREST EXPENSE						113. 00
116. 00 11600		28			0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	44, 463	57, 915	47, 122	92	74, 753	118. 00
	IMBURSABLE COST CENTERS GIFT FLOWER COFFEE SHOP & CAN	0	0	0	ol	0	190. 00
191. 00 19100		0	0		o		191. 00
	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192. 00
	DEKALB MEDICAL SERVICES	803	33, 856	1	0		192. 01
	PHARMACARE NONPALD WORKERS	0	0	0	0		192. 02 193. 00
	OTHER NONREIMBURSABLE COST CENT		0	0	0		194. 00
	ADULT DAY CARE	Ö	Ö	0	ő	0	194. 01
194. 02 07952	FOUNDATION	0	0	0	О	33	194. 02
200.00	Cross Foot Adjustments		_			_	200.00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118-201)	0 45, 266	0 91, 771	0 47, 122	0 92		201. 00 202. 00
202.00	TOTAL (SUIII TITIES TTO-201)	1 40,∠00	71, //1	47,122	92	70,0/0	1202.00

| Peri od: | Worksheet B | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0045

				To	09/30/2016	Date/Time Pre 2/23/2017 4:5	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	J DIII
	·	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		13.00	SUPPLY 14.00	15. 00	16. 00	17. 00	
GENER	RAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	17.00	
1.00 00100	CAP REL COSTS-BLDG & FIXT						1. 00
	1 MAC WEST - NEW						1. 01
	2 NORTH ANNEX - NEW						1. 02
	3 GARRETT CLINIC - NEW						1.03
1	4 BUTLER - NEW 5 MAC EAST - NEW						1. 04 1. 05
1	6 GARRETT LAB - NEW						1.05
	7 MEDICAL ARTS - NEW						1. 07
1.08 00108	B DAY SPRING - NEW						1. 08
1	CAP REL COSTS-MVBLE EQUIP						2. 00
	DEMPLOYEE BENEFITS DEPARTMENT						4. 00
	O ADMINISTRATIVE & GENERAL						5.00
	O OPERATION OF PLANT O LAUNDRY & LINEN SERVICE						7. 00 8. 00
	HOUSEKEEPI NG						9. 00
	D DI ETARY						10.00
10. 01 0100°	1 SNACK BAR						10. 01
	CAFETERI A						11. 00
	O NURSI NG ADMINI STRATI ON	55, 912	50 540				13. 00
	CENTRAL SERVICES & SUPPLY D PHARMACY	1, 048	52, 543				14.00
	DIMEDICAL RECORDS & LIBRARY	0	0		123, 728		15. 00 16. 00
	SOCIAL SERVICE	398	Ö		123, 720	l	17. 00
	TIENT ROUTINE SERVICE COST CENTERS		-			2, 5	
30. 00 03000	DADULTS & PEDIATRICS	17, 367	0	0	12, 359	8, 071	30. 00
	NTENSIVE CARE UNIT	7, 000	0		4, 542	l	31. 00
	NURSERY	1, 316	0	0	785	0	43. 00
	LLARY SERVICE COST CENTERS OF OPERATING ROOM	10, 364	0	O	17, 449	0	50. 00
1	D DELIVERY ROOM & LABOR ROOM	2, 604	0		1, 554		52.00
1	RADI OLOGY-DI AGNOSTI C	0	0		23, 078	l	54. 00
1	LABORATORY	919	0	0	17, 634	0	60.00
60. 01 0600°	1 BLOOD LABORATORY	0	0	0	0	0	60. 01
	RESPI RATORY THERAPY	0	0	0	4, 336	0	65. 00
	PHYSI CAL THERAPY	0	0	0	4, 836	l	66.00
	1 CARDI AC REHAB D ELECTROCARDI OLOGY	0	0	0	372 1, 221	0	66. 01 69. 00
	D ELECTROCARDI OLOGI D ELECTROENCEPHALOGRAPHY	0	0	0	937	0	70.00
	MEDICAL SUPPLIES CHARGED TO PAT	l o	52, 543		8, 635		71. 00
	IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0	i e	72. 00
	DRUGS CHARGED TO PATIENTS	0	0	52, 965	0	0	73. 00
	ATIENT SERVICE COST CENTERS	1					
	O CLI NI C	243	0		149	l .	90.00
	D EMERGENCY D OBSERVATION BEDS (NON-DISTINCT	8, 940	0	0	13, 341	0	91. 00 92. 00
	R REIMBURSABLE COST CENTERS					L	72.00
	O AMBULANCE SERVICES	0	0	0	0	0	95. 00
99. 10 09910	CORF	0	0	0	0	0	99. 10
	D HOME HEALTH AGENCY	5, 309	0	0	0	0	101. 00
	AL PURPOSE COST CENTERS						440.00
116. 00 1160	D I NTEREST EXPENSE	404	0	o	550	0	113. 00 116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	55, 912	52, 543		111, 778		118. 00
	EI MBURSABLE COST CENTERS	00, 712	02,010	02, 700	111,770	0,071	1110.00
	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190. 00
191. 00 19100	RESEARCH	0	0	0	0	0	191. 00
1	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192. 00
	1 DEKALB MEDICAL SERVICES	0	0	0	11, 950		192. 01
	2  PHARMACARE D  NONPAI D  WORKERS		0	0	0		192. 02 193. 00
	O OTHER NONREIMBURSABLE COST CENT		0		0		193.00
	1 ADULT DAY CARE		0	0	0		194. 00
	2 FOUNDATION	l ő	o	Ö	0		194. 02
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118-201)	55, 912	52, 543	52, 965	123, 728	8, 071	202. 00

| Peri od: | Worksheet B | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0045

						To 09/30/2016 Date/Time Pr 2/23/2017 4:	
		Cost Center Description	Subtotal	Intern &	Total	272372017 4.	JO pili
				Residents Cost & Post			
				Stepdown			
			24. 00	Adjustments 25.00	26. 00		
	GENER	AL SERVICE COST CENTERS	24.00	25.00	20.00		
		CAP REL COSTS-BLDG & FIXT					1. 00
		MAC WEST - NEW					1. 01
		NORTH ANNEX - NEW GARRETT CLINIC - NEW					1. 02 1. 03
		BUTLER - NEW					1. 04
		MAC EAST - NEW					1. 05
		GARRETT LAB - NEW					1.06
		MEDICAL ARTS - NEW DAY SPRING - NEW					1. 07 1. 08
		CAP REL COSTS-MVBLE EQUIP					2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT					4. 00
		ADMINISTRATIVE & GENERAL					5. 00
		OPERATION OF PLANT LAUNDRY & LINEN SERVICE					7. 00 8. 00
		HOUSEKEEPI NG					9. 00
		DI ETARY					10. 00
		SNACK BAR					10. 01
		CAFETERIA NURSING ADMINISTRATION					11. 00 13. 00
		CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500	PHARMACY					15. 00
		MEDICAL RECORDS & LIBRARY					16.00
- t		SOCIAL SERVICE ENT ROUTINE SERVICE COST CENTERS					17. 00
		ADULTS & PEDIATRICS	592, 437	0	592, 4	437	30.00
		INTENSIVE CARE UNIT	236, 545	0			31. 00
		NURSERY	40, 473	0	40, 4	473	43. 00
		LARY SERVICE COST CENTERS OPERATING ROOM	754, 054	0	754, (	054	50.00
		DELIVERY ROOM & LABOR ROOM	540, 581	0			52.00
		RADI OLOGY-DI AGNOSTI C	429, 749				54.00
		LABORATORY BLOOD LABORATORY	249, 776	0	,	0	60. 00 60. 01
		RESPIRATORY THERAPY	57, 171	o o		-	65. 00
		PHYSI CAL THERAPY	224, 075				66. 00
		CARDI AC REHAB	108, 672				66. 01
		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	2, 560 2, 488			560 488	69. 00 70. 00
		MEDICAL SUPPLIES CHARGED TO PAT	82, 414				71.00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	13, 602		1		72. 00
		DRUGS CHARGED TO PATIENTS	89, 711	0	89,	711	73. 00
		TIENT SERVICE COST CENTERS CLINIC	1, 594	0	1, !	594	90.00
		EMERGENCY	352, 773		0-0		91.00
		OBSERVATION BEDS (NON-DISTINCT		0			92. 00
		REIMBURSABLE COST CENTERS  AMBULANCE SERVICES	93, 242	0	93. 2	242	95. 00
99. 10			0	Ö		0	99. 10
		HOME HEALTH AGENCY	64, 132	0	64, 1	132	101. 00
		AL PURPOSE COST CENTERS INTEREST EXPENSE			<u> </u>		113. 00
		HOSPI CE	9, 179	0	9	179	116. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	3, 945, 228	l e			118. 00
		MBURSABLE COST CENTERS				ما	100.00
		GIFT FLOWER COFFEE SHOP & CAN RESEARCH	0	0		0	190. 00 191. 00
		PHYSICIANS PRIVATE OFFICES	0	Ö		o	192. 00
		DEKALB MEDICAL SERVICES	1, 207, 295		1, 207, 2		192. 01
		PHARMACARE NONDALD WODKERS	55, 563	0	55, 5	563	192. 02
		NONPALD WORKERS OTHER NONREIMBURSABLE COST CENT	0	0		0	193. 00 194. 00
		ADULT DAY CARE	Ö	Ö		O	194. 01
		FOUNDATI ON	199	0	-	199	194. 02
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers	0	0		0	200. 00 201. 00
201.00		TOTAL (sum lines 118-201)	5, 208, 285	0	5, 208, 2	285	201.00
		· · · · · · · · · · · · · · · · · · ·				•	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0045

Peri od: Worksheet B-1 From 10/01/2015 To 09/30/2016 Date/Time Prepared:

2/23/2017 4:56 pm CAPITAL RELATED COSTS BLDG & FIXT MAC WEST - NEW NORTH ANNEX - GARRETT CLINIC BUTLER - NEW Cost Center Description (SOUARE FEET) NFW (SOUARE FEET) NEW (SQUARE FEET) (SQUARE FEET) (SQUARE FEET) 1.04 1.00 1.01 1.02 1.03 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 205, 077 1.00 00101 MAC WEST - NEW 1.01 1.01 0 16, 334 1.02 00102 NORTH ANNEX - NEW 0 4, 896 1.02 00103 GARRETT CLINIC - NEW 0 1.03 0 0 3, 750 1.03 0 00104 BUTLER - NEW 4, 977 1.04 0 1.04 0 00105 MAC EAST - NEW 0 1.05 0 Ω 1.05 1.06 00106 GARRETT LAB - NEW 0 C 0 0 0 1.06 1.07 00107 MEDICAL ARTS - NEW 0 0 0 0 1.07 ( o 00108 DAY SPRING - NEW 0 0 1 08 0 1 08 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 25, 743 0 0 5.00 0 00700 OPERATION OF PLANT 7 00 80 191 3, 595 0 7 00 0 8.00 00800 LAUNDRY & LINEN SERVICE 1, 194 0 0 8.00 00900 HOUSEKEEPI NG 9.00 1,909 0 0 0 0 0 0 0 9.00 01000 DI ETARY 10 00 1,002 Ω 0 10 00 01001 SNACK BAR 10.01 0 10.01 01100 CAFETERI A 2, 357 11.00 11.00 0 13.00 01300 NURSING ADMINISTRATION 1,060 0 13.00 0 01400 CENTRAL SERVICES & SUPPLY 0 1, 259 14 00 Ω 0 14 00 0 15.00 01500 PHARMACY 1, 158 0 0 0 15.00 2, 795 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 164 0 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 726 0 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 0 0 31.00 4,979 0 31.00 04300 NURSERY 43.00 892 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 741 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 13, 796 52.00 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 9.315 0 0 0 0 54.00 06000 LABORATORY 0 60.00 4, 189 0 784 352 60.00 06001 BLOOD LABORATORY 60.01 60.01 06500 RESPIRATORY THERAPY 65.00 1,092 0 0 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 5, 216 66.00 0 0 06601 CARDI AC REHAB 0 66.01 2.745 0 66.01 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 Λ 0 71.00 Λ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 91.00 09100 EMERGENCY 7,696 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1,757 0 0 0 95.00 0 09910 CORF 0 99. 10 99. 10 C 0 0 0 101.00 10100 HOME HEALTH AGENCY 2.772 0 101.00 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 300 0 116.00 118 00 SUBTOTALS (SUM OF LINES 1-117) 199.976 3.595 3,072 784 352 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 190. 00 0 0 191.00 191. 00 19100 RESEARCH 0 0 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192 00 0 0 0 192. 01 19201 DEKALB MEDICAL SERVICES 5, 101 12, 739 1,824 2, 966 4, 625 192. 01 192. 02 19202 PHARMACARE 0 192. 02 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 194.00 07950 OTHER NONREIMBURSABLE COST CENT 0 0 0 194 00 0 Ω 194.01 07951 ADULT DAY CARE 0 C 0 0 0 194. 01 194. 02 07952 FOUNDATI ON 0 194. 02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 11, 914 202. 00 202.00 4, 958, 324 23, 501 4, 584 16, 587 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 24. 177865 1. 438778 0. 936275 4. 423200 2. 393812 203. 00 Cost to be allocated (per Wkst. B, 204. 00 204.00 Part II)

Health Financial Systems	DEKALB MEMORI.	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1	
				From 10/01/2015 To 09/30/2016	Date/Time Pre 2/23/2017 4:5	
		CAP	ITAL RELATED (	COSTS		
			I			
Cost Center Description	BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX -	GARRETT CLINIC	BUTLER - NEW	
	(SQUARE FEET)		NEW	- NEW	(SQUARE FEET)	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)		
	1.00	1. 01	1. 02	1. 03	1. 04	
205.00 Unit cost multiplier (Wkst. B, Part						205. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0045 

				CAP	TTAL RELATED CO	o 09/30/2016 OSTS	Date/Time Pre 2/23/2017 4:5	
		Cost Center Description	MAC FAST - NF\	GARRETT LAB -		DAY SPRING -	MVBLE EQUIP	
		cost conton boost prion		NEW	NEW	NEW	(SQUARE FEET)	
			1. 05	(SQUARE FEET) 1.06	1. 07	(SQUARE FEET) 1.08	2.00	
1 00		AL SERVICE COST CENTERS			ı			1 00
1. 00 1. 01		CAP REL COSTS-BLDG & FIXT MAC WEST - NEW			•			1.00
1. 02		NORTH ANNEX - NEW			•			1. 02
1.03		GARRETT CLINIC - NEW						1. 03
1. 04 1. 05		BUTLER - NEW MAC EAST - NEW	37, 48°					1. 04 1. 05
1.05		GARRETT LAB - NEW	37, 40					1. 05
1. 07	1	MEDICAL ARTS - NEW	(		8, 575			1. 07
1.08	1	DAY SPRING - NEW	(	0	0	0	005 077	1. 08
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	(		0	0	205, 077 0	2. 00 4. 00
5. 00	1	ADMINISTRATIVE & GENERAL	5, 019	ó	ő	0	25, 743	1
7.00	1	OPERATION OF PLANT	11, 140	0	680	0	80, 191	7. 00
8.00	1	LAUNDRY & LINEN SERVICE	(	0	1	0	1, 194	1
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	70 20	1		0	1, 909 1, 002	1
10. 01	1	SNACK BAR	20		1	0	0	1
11. 00	1	CAFETERI A	(	0	0	0	2, 357	1
13.00	1	NURSI NG ADMINI STRATI ON	(	0	0	0	1, 060	1
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	(		0	0	1, 259 1, 158	1
16. 00	1	MEDICAL RECORDS & LIBRARY	28		Ö	0	2, 795	1
17. 00	-	SOCIAL SERVICE	(	0	0	0	164	17. 00
30. 00	+	I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS		) 0	0	0	11, 726	30.00
31. 00		INTENSIVE CARE UNIT	(	1	1		4, 979	1
43.00		NURSERY	(	0	1		892	1
		LARY SERVICE COST CENTERS			1			
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	(		1		17, 741 13, 796	1
54. 00	1	RADI OLOGY-DI AGNOSTI C	,			0	9, 315	1
60.00	1	LABORATORY	(	0	0	0	4, 189	60. 00
60. 01	1	BLOOD LABORATORY	(	0	0	0	0	
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	(		0	0	1, 092 5, 216	1
66. 01	1	CARDI AC REHAB	(		Ö	0	2, 745	
69. 00	1	ELECTROCARDI OLOGY	(	0	0	0	0	
70. 00 71. 00	1	ELECTROENCEPHALOGRAPHY	(		0	0	0	
71.00		MEDICAL SUPPLIES CHARGED TO PAT IMPL. DEV. CHARGED TO PATIENTS	(		0			1
73. 00		DRUGS CHARGED TO PATIENTS	(		1		Ö	1
		TIENT SERVICE COST CENTERS			1			
90. 00 91. 00		CLI NI C EMERGENCY	(		1	0		90. 00 91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT	•	)		0	7,070	92.00
	OTHER	REIMBURSABLE COST CENTERS						
		AMBULANCE SERVICES	(	1				95. 00
99. 10 101.00		HOME HEALTH AGENCY	(	1	1		<b>l</b>	99. 10 101. 00
		AL PURPOSE COST CENTERS		,				]
		INTEREST EXPENSE		_		_	_	113. 00
116. 00 118. 00		HOSPICE SUBTOTALS (SUM OF LINES 1-117)	16, 72:	) 3	1		<b>l</b>	116.00
110.00	-	IMBURSABLE COST CENTERS	10, 72,	oj	1 000	0	199, 970	1110.00
	19000	GIFT FLOWER COFFEE SHOP & CAN	(	0	0	0	0	190. 00
		RESEARCH	(	0	0	0		191. 00
		PHYSICIANS PRIVATE OFFICES DEKALB MEDICAL SERVICES	20, 758		0 7, 895	0		192. 00 192. 01
		PHARMACARE	20, 730		7, 879	0		192. 02
193.00	19300	NONPALD WORKERS	(	0	0	0	0	193. 00
		OTHER NONREIMBURSABLE COST CENT	(		0	0	l .	194. 00
		ADULT DAY CARE FOUNDATION	(	) 0	0	0	l .	194. 01 194. 02
200.00		Cross Foot Adjustments	`					200. 00
201.00		Negative Cost Centers						201. 00
202.00	)	Cost to be allocated (per Wkst. B,	150, 192	2 0	43, 183	0	0	202. 00
203.00		Part I) Unit cost multiplier (Wkst. B, Part I)	4. 007150	0. 000000	5. 035918	0. 000000	0. 000000	203. 00
204.00		Cost to be allocated (per Wkst. B,	55.16	3. 222300		1.000000	1.000000	204. 00
		Part II)		1	l			<u> </u>

Health Financial Systems	DEKALB MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider Co		Peri od:	Worksheet B-1	
				From 10/01/2015 To 09/30/2016	Date/Time Pre 2/23/2017 4:5	
		CAP	ITAL RELATED	COSTS		
			L			
Cost Center Description	MAC EAST - NEW	GARRETT LAB -	MEDICAL ARTS	- DAY SPRING -	MVBLE EQUIP	
		NEW	NEW	NEW	(SQUARE FEET)	
	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)		
	1.05	1.06	1. 07	1. 08	2. 00	
205.00 Unit cost multiplier (Wkst. B, Part						205. 00

Health Financial Systems	DEKALB MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO	F	eriod: rom 10/01/2015	Worksheet B-1	
			T		2/23/2017 4:5	
Cost Center Description	BENEFITS DEPARTMENT (UNADJUSTED	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
	SALARY) 4. 00	5A	5. 00	7. 00	8. 00	
GENERAL SERVICE COST CENTERS  1. 00   00100   CAP REL COSTS-BLDG & FLXT						1. 00
1.01   00101 MAC WEST - NEW   1.02   00102   NORTH ANNEX - NEW   1.03   00103   GARRETT CLINIC - NEW   1.04   00104   BUTLER - NEW   1.05   00105   MAC EAST - NEW   1.06   00106   GARRETT LAB - NEW   1.07   00107   MEDICAL ARTS - NEW   1.08   00108   DAY SPRING - NEW   1.08   00108   DAY SPRING - NEW   1.09   00200   CAP REL COSTS-MVBLE EQUIP   1.00   00400   EMPLOYEE BENEFITS DEPARTMENT   1.00   00500   ADMINISTRATIVE & GENERAL   1.00   00700   OPERATION OF PLANT   1.00   00900   LAUNDRY & LINEN SERVICE   1.00   00900   HOUSEKEEPING   1.00   01000   DIETARY   1.00   01100   CAFETERIA   13.00   01300   NURSING ADMINISTRATION   14.00   01400   CENTRAL SERVICES & SUPPLY   15.00   01500   PHARMACY   16.00   01600   MEDICAL RECORDS & LIBRARY   1.00   01700   SOCIAL SERVICE   INPATIENT ROUTINE SERVICE   INPATIENT ROUTINE SERVICE   INPATIENT ROUTINE SERVICE   INPATIENT ROUTINE SERVICE   1.00	27, 105, 946 3, 623, 118 576, 302 16, 181 683, 583 209, 458 22, 994 350, 420 825, 105 89, 571 516, 534 499, 678 71, 811	-9, 483, 861 0 0 0 0 0 0 0 0 0 0	4, 154, 918 52, 422 1, 241, 110 422, 466 7, 587 499, 112 1, 043, 506 242, 055 606, 314 739, 487	154, 722 1, 194 1, 985 1, 206 0 2, 357 1, 060 1, 259 1, 158 3, 079 164	303, 942 27, 217 2, 049 0 0 0 0 0	1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 10. 01 11. 00 13. 00 14. 00 15. 00 16. 00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 43. 00   04300   NURSERY	2, 387, 682 969, 366 172, 934	0 0 0	1, 637, 249	11, 726 4, 979 892	87, 566 26, 233 0	31. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   OPERATI NG ROOM	1, 588, 250	0	3, 190, 326	17, 741	42, 834	50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	342, 194 1, 744, 181 1, 287, 928	0 0 0 0	3, 269, 813 3, 686, 729	13, 796 9, 315 5, 325 0	0 35, 454 0 0	54. 00 60. 00
65. 00   06500   RESPI RATORY   THERAPY   66. 00   06600   PHYSI CAL   THERAPY   66. 01   06601   CARDI AC   REHAB   69. 00   06900   ELECTROCARDI OLOGY   70. 00   07000   ELECTROENCEPHALOGRAPHY   71. 00   07100   MEDI CAL   SUPPLI ES   CHARGED   TO   PAT	527, 684 274, 702 146, 389 60, 018 49, 294	0 0 0 0 0	1, 540, 005 241, 377 78, 659 80, 275	1, 092 5, 216 2, 745 0 0	0 6, 069 1, 216 0 2, 139 0	66. 01 69. 00 70. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1, 121, 414	0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	3, 029, 577	0	0	73. 00
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY 92. 00   09200   0BSERVATI ON   BEDS   (NON-DI STI NCT   OTHER   REI MBURSABLE   COST   CENTERS	58, 723 1, 283, 950	0	· ·	0 7, 696	1, 411 54, 506	90. 00 91. 00 92. 00
95. 00 09500 AMBULANCE SERVICES	1, 155, 404	0			11, 673	
99. 10   09910   CORF 101. 00   10100   HOME   HEALTH   AGENCY	744, 256	0		0 2, 772	0	99. 10 101. 00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   116.00   11600   HOSPI CE   118.00   SUBTOTALS (SUM OF LINES 1-117)	79, 924 20, 357, 634	0 -9, 483, 861	287, 787	300 98, 814	186 298, 553	113. 00 116. 00 118. 00
NONREI MBURSABLE COST CENTERS  190. 00   19000   GIFT   FLOWER   COFFEE SHOP & CAN	0	0	0	O	0	190. 00
191. 00   19100   RESEARCH 192. 00   19200   PHYSI CLANS   PRI VATE   OFFI CES 192. 01   19201   DEKALB   MEDI CAL   SERVI CES 192. 02   19202   PHARMACARE 193. 00   19300   NONPAI D   WORKERS 194. 00   07950   OTHER   NONREI MBURSABLE   COST   CENT 194. 01   07951   ADULT   DAY   CARE	0 0 6, 291, 947 447, 163 0 0	0 0 0 0 0 0		0 0 55, 908 0 0 0	0 0 5, 389 0 0 0	191. 00 192. 00 192. 01 192. 02 193. 00 194. 00 194. 01
194.02 07952 FOUNDATION 200.00 Cross Foot Adjustments Negative Cost Centers	9, 202	0	13, 718		0	194. 02 200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	671, 597		9, 483, 861	4, 898, 769	99, 611	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0. 024777 0		0. 179029 642, 523		0. 327730 45, 266	203. 00 204. 00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
				rom 10/01/2015		
				o 09/30/2016	Date/Time Pre 2/23/2017 4:5	
Cook Cooker Doored at the	EMDL OVEE	D:   : -+:	ADMINI CEDATIVE	ODEDATION OF		o piii
Cost Center Description		Reconciliation			LAUNDRY &	
	BENEFITS		& GENERAL	PLANT	LINEN SERVICE	
	DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF	
	(UNADJUSTED		,	,	LAUNDRY)	
	SALARY)					
	4. 00	5A	5. 00	7. 00	8. 00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000		0. 012129	13. 200941	0. 148930	205. 00

Heal th Financial Systems

DEKALB MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0045

From 10/01/2015
To 09/30/2016

Date/Time Prepared: 2/23/2017 4:56 pm

Cost Center Description

HOUSEKEEPING (SQUARE FEET) (MEALS SERVED) (MEALS SERVED)

(DI RECT NRS ING)

9.00 10.00 10.01 11.00 13.00

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON	<del>у р</del> ш
						(DI RECT NRS	
		9. 00	10.00	10. 01	11.00	I NG) 13. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT 00101 MAC WEST - NEW						1. 00 1. 01
	00102 NORTH ANNEX - NEW						1. 02
	00103 GARRETT CLINIC - NEW						1. 03
	00104 BUTLER - NEW						1. 04
	00105 MAC EAST - NEW 00106 GARRETT LAB - NEW						1. 05 1. 06
	00107 MEDICAL ARTS - NEW						1. 07
	00108 DAY SPRING - NEW						1. 08
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
	00500 ADMI NI STRATI VE & GENERAL						5. 00
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE	454 540					8. 00
	00900 HOUSEKEEPI NG 01000 DI ETARY	151, 543 1, 206	l				9. 00 10. 00
	01001 SNACK BAR	1, 200		1			10. 00
	01100 CAFETERI A	2, 357	0	100	34, 802		11. 00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	1,060	ł		1, 088	297, 406	
	01500 PHARMACY	1, 259 1, 158	ł		268 591	5, 573 0	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	3, 079			1, 285	0	16. 00
17. 00	01700 SOCIAL SERVICE	164	0	0	102	2, 117	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	11, 726	25, 181	0	4, 442	92, 385	30. 00
	03100   NTENSIVE CARE UNIT	4, 979			1, 790	37, 233	
	04300 NURSERY	892	0	1	336	6, 999	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	47.744			0 (50	55 400	F0 00
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	17, 741 13, 796	0		2, 650 666	55, 130 13, 849	50. 00 52. 00
	05400 RADI OLOGY-DI AGNOSTI C	9, 315	l e		2, 876	0	54. 00
	06000 LABORATORY	5, 325	l e		2, 690	4, 888	60.00
	06001 BL00D LABORATORY 06500 RESPI RATORY THERAPY	0 1, 092	0	- 1	0 959	0	60. 01 65. 00
	06600 PHYSI CAL THERAPY	5, 216	l		556 556	0	66. 00
	06601 CARDI AC REHAB	2, 745			336	0	66. 01
	06900 ELECTROCARDI OLOGY	0	0	0	140	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	94 0	0	70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	0		(2)	1, 293	90. 00
	09100 EMERGENCY	0 7, 696	l		62 2, 286	47, 553	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT		_		,	,	92.00
	OTHER REIMBURSABLE COST CENTERS	4 757	_		0.400		05.00
	09500 AMBULANCE SERVICES 09910 CORF	1, 757 0	0		2, 498 0	0	95. 00 99. 10
	10100 HOME HEALTH AGENCY	2, 772			1, 374	28, 237	
112 00	SPECIAL PURPOSE COST CENTERS			I			112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	300	0	0	103	2 149	113. 00 116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	95, 635			27, 192	297, 406	
	NONREI MBURSABLE COST CENTERS	_	_		-1		
	19000 GIFT FLOWER COFFEE SHOP & CAN 19100 RESEARCH	0	0		0		190. 00 191. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0		0		191.00
192. 01	19201 DEKALB MEDICAL SERVICES	55, 908	0	0	6, 774	0	192. 01
	19202 PHARMACARE	0	0		824		192. 02
	19300 NONPALD WORKERS 07950 OTHER NONRELMBURSABLE COST CENT	0	0	0	0		193. 00 194. 00
	07951 ADULT DAY CARE	Ö	ő	Ö	Ö		194. 01
	07952 FOUNDATI ON	0	0	0	12	0	194. 02
200.00	1						200.00
201. 00 202. 00		1, 535, 074	549, 172	8, 945	695, 916	1, 296, 378	201. 00 202. 00
	Part I)						
203.00		10. 129627	l e	I	19. 996437	4. 358950	
204. 00	Cost to be allocated (per Wkst. B, Part II)	91, 771	47, 122	92	95, 675	55, 912	∠U4. UU
		•	•	. '		•	

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 10/01/2015		
				To 09/30/2016	Date/Time Pre 2/23/2017 4:5	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	NURSI NG	
	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED	) (FTES)	ADMI NI STRATI ON	
					(DI RECT NRS	
					I NG)	
	9. 00	10.00	10. 01	11. 00	13. 00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 605577	1. 585692	0. 92000	0 2. 749124	0. 187999	205. 00
		I	l	l	I	1

30.00	03000 ADULTS & PEDIATRICS	0	0	14, 043, 861	100	30.00
31.00	03100 INTENSIVE CARE UNIT	o	0	5, 161, 775	0	31.00
43.00	04300 NURSERY	0	0	892, 349	0	43. 00
P	NCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	19, 828, 301	0	50.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0	0	1, 765, 740	0	52. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0	0	26, 146, 010	0	54.00
60.00	06000 LABORATORY	0	0	20, 038, 458	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	60. 01
65. 00	06500 RESPIRATORY THERAPY	0	0	4, 927, 417	O	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	5, 495, 553	O	66. 00
66. 01	06601 CARDI AC REHAB	0	0	422, 242	O	66. 01
69.00	06900 ELECTROCARDI OLOGY	o	0	1, 387, 710	O	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	O	0	1, 064, 996	O	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	100	0	9, 812, 474	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	o	o	0	O	72. 00
	07300 DRUGS CHARGED TO PATIENTS	o	100	0	o	73. 00
_	OUTPATIENT SERVICE COST CENTERS	-1		-1		
	09000 CLI NI C	0	0	169, 118	0	90.00
	09100 EMERGENCY	o	o	15, 160, 217	o	91.00
4	09200 OBSERVATION BEDS (NON-DISTINCT		Ĭ	10/100/21/	Ĭ	92.00
	OTHER REIMBURSABLE COST CENTERS		,			72.00
	09500 AMBULANCE SERVI CES	0	0	0	0	95. 00
	09910 CORF	o	o	0	o	99. 10
	10100 HOME HEALTH AGENCY		o	0	o	101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	۷۱	0	<u> </u>	101.00
	11300 I NTEREST EXPENSE					113. 00
1	11600 HOSPI CE	o	o	624, 902	o	116.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	100	100	126, 941, 123	100	118.00
	IONREI MBURSABLE COST CENTERS	100	100	120, 741, 123	100	110.00
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	O	0	O	190. 00
	19100 RESEARCH		o	0	0	191.00
	19200 PHYSICIANS PRIVATE OFFICES		o	0	0	192.00
	19201 DEKALB MEDICAL SERVICES	0	0	13, 579, 564	0	192. 00
	19202 PHARMACARE		0	13, 377, 304	0	192. 01
	19300 NONPALD WORKERS	0	0	0		193. 00
	07950 OTHER NONREIMBURSABLE COST CENT	0	0	0	0	194. 00
		0	0	0	0	
	07951 ADULT DAY CARE	0	0	0	0	194. 01
	07952 FOUNDATI ON	U	U	U	٩	194. 02
200.00	Cross Foot Adjustments					200. 00
201.00	Negative Cost Centers					201. 00
202. 00	Cost to be allocated (per Wkst. B,	367, 656	775, 074	1, 026, 248	131, 316	202. 00
	Part I)	0 474 540000		0.007000	4 040 4/0000	
203.00	Unit cost multiplier (Wkst. B, Part I)	3, 676. 560000	7, 750. 740000	0. 007303		203. 00
204. 00	Cost to be allocated (per Wkst. B,	52, 543	52, 965	123, 728	8, 071	204. 00
T.	Part II)					ļ
MCDI E22						
いル・ストトイノ						
WORT 1 02	- 10. 2. 159. 1					
morri 7 02	- 10. 2. 159. 1					

Health Financial Systems	DEKALB MEMORI.	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
				From 10/01/2015 To 09/30/2016	Date/Time Pre 2/23/2017 4:5	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
	SERVICES &	(COSTED	RECORDS &			
	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)		
	(COSTED		(GROSS REVE			
	REQUIS.)		NUE)			
	14. 00	15. 00	16. 00	17. 00		
205.00 Unit cost multiplier (Wkst. B, Part	525. 430000	529. 650000	0. 000880	80. 710000		205. 00
						1

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 15-0045	Peri od: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Pre 2/23/2017 4:5	
		Ti tl	e XVIII	Hospi tal	PPS	
				C+-		

				'	0 09/30/2010	2/23/2017 4:5	
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	5, 991, 773		5, 991, 773	0	5, 991, 773	30.00
31.00 031	00 INTENSIVE CARE UNIT	2, 466, 653		2, 466, 653	0	2, 466, 653	31. 00
	800 NURSERY	427, 629		427, 629	0	427, 629	43. 00
	ILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	4, 955, 052		4, 955, 052		4, 955, 052	
	200 DELIVERY ROOM & LABOR ROOM	1, 689, 554		1, 689, 554		1, 689, 554	
	IOO RADI OLOGY-DI AGNOSTI C	4, 504, 589		4, 504, 589	0	4, 504, 589	54.00
	000 LABORATORY	4, 790, 737		4, 790, 737	0	4, 790, 737	60.00
	001 BLOOD LABORATORY	0		(	0	0	60. 01
	00 RESPI RATORY THERAPY	948, 537	0	948, 537		948, 537	65. 00
66.00 066	00 PHYSI CAL THERAPY	2, 086, 936	0	2, 086, 936	0	2, 086, 936	66. 00
	01 CARDI AC REHAB	409, 509	0	409, 509	0	409, 509	66. 01
69.00 069	POO ELECTROCARDI OLOGY	105, 675		105, 675	0	105, 675	69. 00
70.00 070	000 ELECTROENCEPHALOGRAPHY	105, 006		105, 006	0	105, 006	70. 00
71.00 071	00 MEDICAL SUPPLIES CHARGED TO PAT	2, 503, 639		2, 503, 639	0	2, 503, 639	71. 00
72.00 072	200 IMPL. DEV. CHARGED TO PATIENTS	1, 322, 180		1, 322, 180	0	1, 322, 180	72. 00
73.00 073	BOO DRUGS CHARGED TO PATIENTS	4, 347, 033		4, 347, 033	0	4, 347, 033	73. 00
	PATIENT SERVICE COST CENTERS						
	000 CLI NI C	88, 436		88, 436		88, 436	90.00
91.00 091	00 EMERGENCY	3, 013, 040		3, 013, 040	0	3, 013, 040	91. 00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT	1, 389, 416		1, 389, 416	b	1, 389, 416	92. 00
	IER REI MBURSABLE COST CENTERS						
	500 AMBULANCE SERVICES	1, 867, 025		1, 867, 025	0	1, 867, 025	
99. 10 099	P10 CORF	0		(		0	99. 10
	00 HOME HEALTH AGENCY	1, 644, 747		1, 644, 747	7	1, 644, 747	101. 00
SPE	CLAL PURPOSE COST CENTERS						
113. 00 113	300 INTEREST EXPENSE						113. 00
116. 00 116	000 HOSPI CE	367, 899		367, 899		367, 899	116. 00
200.00	Subtotal (see instructions)	45, 025, 065	0	45, 025, 065	0	45, 025, 065	200. 00
201.00	Less Observation Beds	1, 389, 416		1, 389, 416	<b>b</b>	1, 389, 416	201. 00
202.00	Total (see instructions)	43, 635, 649	0	43, 635, 649	o	43, 635, 649	202. 00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der 0	From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Prepared: 2/23/2017 4:56 pm

Title xVIII						0 09/30/2016	Date/lime Pre   2/23/2017 4:5	pared:
Cost Center Description				Title	XVIII	Hospi tal		о рііі
Inpati ent   Outpati ent   Outpati ent   Total (col. 6   Cost or Other   Ratio   Rat								
INPATIENT ROUTINE SERVICE COST CENTERS		Cost Center Description	I npati ent		Total (col. 6	Cost or Other	TEFRA	
INPATI ENT ROUTINE SERVICE COST CENTERS   10, 922, 874   10, 922, 874   31. 00   33000   ADULTS & PEDI ATRI CS   10, 922, 874   4, 697, 421   31. 00   33000   ADULTS & PEDI ATRI CS   10, 922, 874   4, 697, 421   31. 00   34. 0		'	·	·	+ col. 7)	Ratio	I npati ent	
IMPATI ENT ROUTINE SERVICE COST CENTERS								
30. 00   03000   ADULTS & PEDIATRICS   10, 922, 874   4, 697, 421   4, 697, 421   31. 00			6. 00	7. 00	8. 00	9. 00	10.00	
31.00   03100   NTENSI VE CARE UNIT   4,697,421   874,272   874,272   430   04300   NURSERY   874,272   874,272   874,272   43.00   04300   NURSERY SERVI CE COST CENTERS   874,272   874,272   874,272   43.00   04300   NURSERY SERVI CE COST CENTERS   874,272   874,274   874,272   874,								
43.00	30.00	1 1	10, 922, 874		10, 922, 874			30. 00
ANCI LLARY SERVICE COST CENTERS	31. 00		4, 697, 421					31. 00
50.00     05000     OFERATI NG ROOM   1,714,4   40,0   15,409,312   19,586,506   0.252983   0.000000   50.00   52.00   52.00   05200   DELI VERY ROOM & LABOR ROOM   1,744,940   6,986   1,751,926   0.964398   0.000000   52.00   60.00   05400   RADIO LOGY-DI AGNOSTI C   1,801,634   24,004,702   25,806,336   0.174554   0.000000   62.00   60.	43.00		874, 272		874, 272			43. 00
52.00   05200   DELI VERY ROOM & LABOR ROOM   1,744,940   6,986   1,751,926   0.964398   0.000000   52.00								
54.00   05400   RADI OLOGY-DI AGNOSTI C   1,801,634   24,004,702   25,806,336   0.174554   0.000000   54.00   60.00   60.000   LABORATORY   3,371,815   19,902,633   23,274,448   0.205837   0.000000   60.0								
60.00   06000   LABORATORY   3, 371, 815   19, 902, 633   23, 274, 448   0. 205837   0. 000000   60. 00   60. 00   60. 01   60001   BLOOD LABORATORY   0 0 0 0 0 0.000000   0. 0000000   60. 01   65. 00   06500   RESPIRATORY THERAPY   3, 737, 032   1, 145, 472   4, 882, 504   0. 194273   0. 000000   65. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 01   66601   CARDI AC REHAB   3, 938   412, 677   416, 615   0. 982943   0. 000000   66. 01   69. 00   6900   ELECTROCARDI OLOGY   226, 505   1, 143, 912   1, 370, 417   0. 077112   0. 000000   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0 1, 050, 748   0. 099935   0. 000000   70. 00   71. 00   72. 00   73.00   MEDI CAL SUPPLI ES CHARGED TO PAT   1, 767, 356   2, 808, 845   4, 576, 201   0. 547100   0. 000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   3, 495, 947   1, 670, 935   5, 166, 882   0. 255895   0. 000000   73. 00   07300   DRUGS CHARGED TO PATI ENTS   2, 256, 529   4, 739, 682   6, 996, 211   0. 621341   0. 000000   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   00				· ·				
60.01   06001   BLOOD LABORATORY   0   0   0   0.000000   0.000000   60.01   65.00   06500   RESPI RATORY THERAPY   3,737,032   1,145,472   4,882,504   0.194273   0.000000   65.00   66.01   06601   CARDI AC REHAB   3,938   412,677   416,615   0.982943   0.000000   66.01   69.00   06900   ELECTROCARDI OLOGY   226,505   1,143,912   1,370,417   0.077112   0.000000   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   0   1,050,748   1,050,748   0.099935   0.000000   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PAT   1,767,356   2,808,845   4,576,201   0.547100   0.000000   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   3,495,947   1,670,935   5,166,882   0.255895   0.000000   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   2,256,529   4,739,682   6,996,211   0.621341   0.000000   73.00   01100   MERGENCY   2,430,327   12,540,042   14,970,369   0.201267   0.000000   91.00   91.00   09100   EMERGENCY   2,430,327   12,540,042   14,970,369   0.201267   0.000000   92.00   92.00   OBSERVATION BEDS (NON-DISTINCT   0 3,428,447   3,428,447   0.405261   0.000000   92.00   95.00   99.10   O9910   CORF   0 0 0 0 0   0   91.10   O9910   LORF   ELIMBURSABLE COST CENTERS   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000000	54.00		1, 801, 634	24, 004, 702	25, 806, 336	0. 174554	0.000000	54.00
65. 00	60.00		3, 371, 815	19, 902, 633	23, 274, 448		0.000000	60.00
66. 00	60. 01		0	0	C		0.000000	60. 01
66. 01 06601 CARDIAC REHAB 3, 938 412, 677 416, 615 0. 982943 0. 000000 66. 01 69. 00 06900 ELECTROCARDIOLOGY 226, 505 1, 143, 912 1, 370, 417 0. 077112 0. 000000 69. 00 70. 00 70. 00 ELECTROCARDIOLOGY 0 1, 050, 748 1, 050, 748 0. 099935 0. 000000 70. 00 7100 MEDI CAL SUPPLIES CHARGED TO PAT 1, 767, 366 2, 808, 845 4, 576, 201 0. 547100 0. 000000 71. 00 72. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 3, 495, 947 1, 670, 935 5, 166, 882 0. 255895 0. 000000 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 73. 00 07400 IMPL. DEV. CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 73. 00 07400 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 73. 00 07400 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 73. 00 07400 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 73. 00 07400 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 90. 00 07400 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 90. 00 07400 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 90. 00 07400 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 90. 00 07400 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 90. 00 07400 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 90. 00 07400 DRUGS CHARGED TO PATIENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 0000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 0000000 90. 00 00000000	65.00		3, 737, 032	1, 145, 472	4, 882, 504	0. 194273		
69. 00   06900   ELECTROCARDI OLOGY   226, 505   1, 143, 912   1, 370, 417   0. 077112   0. 000000   69. 00   70. 00   7	66.00	06600 PHYSI CAL THERAPY	911, 895	4, 515, 261	5, 427, 156	0. 384536	0.000000	66. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 1, 050, 748 1, 050, 748 0. 099935 0. 000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 1, 767, 356 2, 808, 845 4, 576, 201 0. 547100 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 3, 495, 947 1, 670, 935 5, 166, 882 0. 255895 0. 000000 72. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 256, 529 4, 739, 682 6, 996, 211 0. 621341 0. 000000 72. 00 00000 CLI NI C 0. 000000 CLI NI C 0. 000000 CLI NI C 0. 000000 P. 0. 000000 P. 0. 00 09000 CLI NI C 0. 000000 P. 0. 00 09100 EMERGENCY 0. 000000 P. 0. 00 09100 EMERGENCY 0. 000000 P. 0. 000000 P. 0. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT 0. 3, 428, 447 0. 405261 0. 000000 P. 0. 00 09500 AMBULANCE SERVI CES 0. 0. 000000 P. 0. 00 09500 AMBULANCE SERVI CES 0. 0. 000000 P. 0. 00 09910 CORF 0. 0. 000000 P. 0. 00 09910 CORF 0. 0. 000000 P. 0. 00 0 0 0 0 0 0 0 0 0	66. 01	06601 CARDI AC REHAB	3, 938	412, 677	416, 615	0. 982943	0.000000	66. 01
71. 00	69. 00	06900 ELECTROCARDI OLOGY	226, 505	1, 143, 912	1, 370, 417	0. 077112	0.000000	69. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   3, 495, 947   1, 670, 935   5, 166, 882   0. 255895   0. 000000   72. 00   07300   DRUGS CHARGED TO PATIENTS   2, 256, 529   4, 739, 682   6, 996, 211   0. 621341   0. 000000   73. 00   000000   00000000000000000000000	70.00	07000 ELECTROENCEPHALOGRAPHY	0	1, 050, 748	1, 050, 748	0. 099935	0.000000	70. 00
73. 00	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 767, 356	2, 808, 845	4, 576, 201	0. 547100	0.000000	71. 00
OUTPATI ENT SERVICE COST CENTERS   130			3, 495, 947	1, 670, 935	5, 166, 882	0. 255895	0.000000	72. 00
90. 00   09000   CLINIC   130   166, 726   166, 856   0.530014   0.000000   90.00   91.00   91.00   99	73.00		2, 256, 529	4, 739, 682	6, 996, 211	0. 621341	0. 000000	73. 00
91. 00   09100   EMERGENCY   2, 430, 327   12, 540, 042   14, 970, 369   0. 201267   0. 000000   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT   0   3, 428, 447   3, 428, 447   0. 405261   0. 000000   92. 00   000000   92. 00   0000000   93. 00   0000000   94. 00   0000000   95. 00   00000000000000000000000000000000								
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT   0   3,428,447   3,428,447   0.405261   0.000000   92.00	90.00			166, 726	166, 856			
OTHER REIMBURSABLE COST CENTERS           95. 00         09500 AMBULANCE SERVI CES         0         5, 684, 137         5, 684, 137         0. 328462         0. 000000         95. 00         99. 10           101. 00         10100 HOME HEALTH AGENCY         0         1, 167, 558         1, 167, 558         101. 00           SPECIAL PURPOSE COST CENTERS           113. 00         1 THEREST EXPENSE         113. 00         11300 HOSPI CE         42, 168         582, 734         624, 902         116. 00         116. 00         200. 00         Subtotal (see instructions)         42, 461, 977         100, 380, 809         142, 842, 786         200. 00         201. 00	91.00	09100 EMERGENCY	2, 430, 327	12, 540, 042	14, 970, 369	0. 201267	0.000000	91.00
95. 00   99. 00   90. 00   99. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90.	92.00		0	3, 428, 447	3, 428, 447	0. 405261	0.000000	92. 00
99. 10   09910   CORF   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   1, 167, 558   1, 167, 558   101. 00   13. 00   13. 00   13. 00   13. 00   13. 00   13. 00   10. 00								
101. 00   10100   HOME   HEALTH   AGENCY   0   1, 167, 558   1, 167, 558   101. 00   SPECIAL   PURPOSE   COST   CENTERS   113. 00   11300   INTEREST   EXPENSE   116. 00   116.00   HOSPI   CE   42, 168   582, 734   624, 902   116. 00   200. 00   Subtotal (see i instructions)   42, 461, 977   100, 380, 809   142, 842, 786   200. 00   201. 00   Less   Observation   Beds   101. 00   101.			0	5, 684, 137	5, 684, 137	0. 328462	0.000000	
SPECIAL PURPOSE COST CENTERS   113.00   11300   NTEREST EXPENSE   114.00   116.00			0	· ·				
113.00	101.00		0	1, 167, 558	1, 167, 558			101. 00
116. 00   11600   HOSPI CE		SPECIAL PURPOSE COST CENTERS						
200.00       Subtotal (see instructions)       42,461,977       100,380,809       142,842,786       200.00         201.00       Less Observation Beds       201.00								
201.00 Less Observation Beds 201.00	116.00	11600 H0SPI CE	42, 168	582, 734	624, 902			116. 00
	200.00		42, 461, 977	100, 380, 809	142, 842, 786			200. 00
202. 00   Total (see instructions)   42, 461, 977   100, 380, 809   142, 842, 786   202. 00	201.00							
	202.00	Total (see instructions)	42, 461, 977	100, 380, 809	142, 842, 786			202. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der	rom 10/01/2015 o 09/30/2016	Worksheet C Part I Date/Time Prepared: 2/23/2017 4:56 pm

NPATIENT ROUTINE SERVICE COST CENTERS   11.00   11.0						2/23/2017 4:5	56 pm
NPATIENT ROUTINE SERVICE COST CENTERS   11.00   11.00   13.00   03000   ADULTS & PEDI ATRICS   30.00   31.00   03100   INTENSI VE CARE UNIT   31.00   043.00   NURSERY   43.00   04300   NURSERY   43.00   05200   DELI VERY ROOM & 0.252983   50.00   05200   DELI VERY ROOM & 0.964398   52.00   05200   DELI VERY ROOM & LABOR ROOM   0.964398   52.00   05200   DELI VERY ROOM & LABOR ROOM   0.205837   66.00   06000   LABORATORY   0.205837   66.00   06000   LABORATORY   0.205837   66.00   06000   CABORATORY   0.000000   06.00   06000   LABORATORY   0.000000   06.00   06000   CABORATORY   0.000000   06.00   06000   CABORATORY   0.000000   06.00   060000   06000   060000   060000   060000   060000   060000   060000   060000   06000				Title XVIII	Hospi tal	PPS	
INPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   33.00   ADULTS & PEDI ATRI CS   31.00   33.00   INTENSI VE CARE UNI T   31.00   34.00   ADULTS & PEDI ATRI CS   31.00   34.00   AUSSERY		Cost Center Description	PPS Inpatient				
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   30							
30. 00   3300   ADULTS & PEDIATRICS   30. 00   31. 00   3310   1NTENSI VE CARE UNIT   31. 00   300   1NTENSI VE CARE UNIT   43. 00   43. 00   4300   NURSERY   43. 00   43. 00   4300   NURSERY   43. 00   43. 00   4300   NURSERY   43. 00			11. 00				
31. 00							
43. 00   04300   NURSERY							
ANCI LLARY SERVI CE COST CENTERS   50.00   05000   OPERATI NG ROOM   0.252983   50.00   52.00   05200   DELIVERY ROOM & LABOR ROOM   0.964398   52.00   05400   RADI OLOGY - DI AGNOSTI C   0.174554   54.00   60.00   06000   LABORATORY   0.205837   60.00   06000   LABORATORY   0.000000   65.00   06500   RESPI RATORY THERAPY   0.194273   65.00   06500   RESPI RATORY THERAPY   0.384536   66.00   06001   CARDI AC REHAB   0.982943   66.00   06900   ELECTROCARDI OLOGY   0.077112   69.00   06900   ELECTROCARDI OLOGY   0.077112   69.00   07000   ELECTROCARDI OLOGY   0.077112   69.00   071.00   07100   MEDI CAL SUPPLI ES CHARGED TO PAT   0.547100   07200   IMPL. DEV. CHARGED TO PAT   0.547100   07200   IMPL. DEV. CHARGED TO PAT   0.547100   07300   DRUGS CHARGED TO PAT   0.525895   72.00   07300   DRUGS CHARGED TO PAT   0.547100   0.0000   00000   CLIN IC   0.201267   90.00   09100   EMERGENCY   0.201267   91.00   09100   EMERGENCY   0.201267   91.00   09100   EMERGENCY   0.201267   92.00   07100   MEBIGENCY   0.201267   92.00   07100   07100   MEBIGENCY   0.201267   92.00   07100   07100   07100   07100   07100   07100   07100   07100   07100   07100   07100   07100   07100   07100   07100   07100   07100   07100   07100							
50. 00       05000   OPERATI NG ROOM       0. 252983       50. 00         52. 00       05200   DELI VERY ROOM & LABOR ROOM       0. 964398       52. 00         54. 00       05400   RADI OLOGY-DI AGNOSTI C       0. 174554       54. 00         60. 00       06000   LABORATORY       0. 205837       66. 00         60. 01       06500   RESPI RATORY THERAPY       0. 194273       65. 00         66. 00       06600   PHYSI CAL THERAPY       0. 384536       66. 00         66. 01       06601   CARDI AC REHAB       0. 982943       66. 01         69. 00       06900   ELECTROCARDI OLOGY       0. 077112       69. 00         70. 00       07000   ELECTROCKEPHALOGRAPHY       0. 099935       70. 00         71. 00       07100   MEDI CAL SUPPLIES CHARGED TO PAT       0. 547100       71. 00         72. 00       07200   IMPL. DEV. CHARGED TO PATI ENTS       0. 255895       72. 00         73. 00       07300   DRUGS CHARGED TO PATI ENTS       0. 621341       73. 00         00THERT IEST SERVICE COST CENTERS       0. 201267       91. 00         92. 00       09000   CLI NI C       0. 530014       92. 00         09500   AMBULANCE SERVICES       0. 328462       95. 00         99. 10       09910   CORF       95. 00	43.00						43. 00
52.00   05200   DELI VERY ROOM & LABOR ROOM   0.964398   52.00							
54. 00       05400 RADI OLOGY-DI AGNOSTI C       0. 174554       54. 00         60. 00       06000 LABORATORY       0. 205837       60. 00         60. 01       06001 BLOOD LABORATORY       0. 000000       60. 01         65. 00       06500 RESPI RATORY THERAPY       0. 194273       65. 00         66. 00       06600 PHYSI CAL THERAPY       0. 384536       66. 00         66. 01       06601 CARDI AC REHAB       0. 982943       66. 01         69. 00       06900 ELECTROCARDI OLOGY       0. 077112       69. 00         70. 00       07000 ELECTROCARDI ACORAPHY       0. 099935       70. 00         71. 00       07100 MEDI CAL SUPPLI ES CHARGED TO PAT       0. 547100       71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0. 255895       72. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0. 621341       73. 00         90. 00       09000 CLI NI C       0. 530014       90. 00         91. 00       09100 EMERGENCY       0. 201267       91. 00         92. 00       09200 DSSERVATI ON BEDS (NON-DI STI NCT)       0. 405261       92. 00         95. 00       09500 AMBULANCE SERVI CES       0. 328462       95. 00	50.00		0. 252983				
60. 00   06000   LABORATORY   0. 205837   60. 00   60. 01   06001   BLOOD LABORATORY   0. 0000000   60. 01   65. 00   06500   RESPI RATORY THERAPY   0. 194273   65. 00   66.	52.00						
60. 01   06001   06001   06001   06001   06001   06001   06000   06500   06500   06500   06500   06500   06500   06500   06500   06600	54.00		0. 174554				54.00
65. 00	60.00	06000 LABORATORY	0. 205837				60.00
66. 00   06600   06600   06600   06600   06600   06601	60. 01	06001 BLOOD LABORATORY	0. 000000				60. 01
66. 01 06601 CARDI AC REHAB 0. 982943 66. 01 69. 00 06900 ELECTROCARDI OLOGY 0. 0777112 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 0. 099935 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0. 547100 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 255895 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 621341 73. 00 0UTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0. 530014 91. 00 91. 00 09100 EMERGENCY 0. 201267 91. 00 92. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT 0. 405261 92. 00 07100 O9500 AMBULANCE SERVI CES 0. 328462 99. 10 99. 10 09910 CORF	65.00	06500 RESPI RATORY THERAPY	0. 194273				65. 00
69. 00   06900   ELECTROCARDI OLOGY   0. 077112   69. 00   70. 00   70. 00   70. 00   ELECTROENCEPHALOGRAPHY   0. 099935   70. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   73. 00	66.00	06600 PHYSI CAL THERAPY	0. 384536				66. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 099935   70. 00   07100   MEDI CAL SUPPLIES CHARGED TO PAT   0. 547100   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 255895   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 621341   73. 00   00000   00000   0000   00000   00000   0000   0000   0000   0000   0000   0000   0000   00	66. 01	06601 CARDI AC REHAB	0. 982943				66. 01
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PAT   0. 547100   72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   0. 255895   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 621341   73. 00   0000	69.00	06900 ELECTROCARDI OLOGY	0. 077112				69. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 255895   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 621341   73. 00   0UTPATIENT SERVICE COST CENTERS   90. 00   09100   EMERGENCY   0. 201267   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT   0. 405261   92. 00   07100   CMFR REIMBURSABLE COST CENTERS   95. 00   09910   CORF   99. 10   09910   CORF   99. 10   09910   CORF   99. 10   09910   CORF   99. 10   00. 201267   99. 10   00. 328462   95. 00   99. 10   00. 328462	70.00	07000 ELECTROENCEPHALOGRAPHY	0. 099935				70. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 621341   73. 00   0UTPATIENT SERVICE COST CENTERS   90. 00   09000   CLI NI C   0. 530014   90. 00   91. 00   09100   EMERGENCY   0. 201267   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT   0. 405261   92. 00   09500   AMBULANCE SERVICES   0. 328462   95. 00   99. 10   09910   CORF   99. 10	71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 547100				71. 00
OUTPATIENT SERVICE COST CENTERS   90. 00   09000   CLINIC   0. 530014   90. 00   91. 00   09100   EMERGENCY   0. 201267   91. 00   09200   09SERVATION BEDS (NON-DISTINCT   0. 405261   92. 00   07HER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   0. 328462   95. 00   99. 10   09910   CORF   99. 10   09910   CORF   99. 10   09910   CORF   99. 10   09910	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 255895				72. 00
90. 00   09000   CLI NI C   0. 530014   90. 00   09100   EMERGENCY   0. 201267   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT   0. 405261   92. 00   071HER REI MBURSABLE COST CENTERS   0. 328462   95. 00   09910   CORF   0. 328462   99. 10   09910   CORF	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 621341				73. 00
91. 00   09100   EMERGENCY   0. 201267   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT   0. 405261   92. 00   071HER REI MBURSABLE COST CENTERS   0. 328462   95. 00   09910   CORF   0. 991. 00   09910   CORF   99. 10   09910   CORF   0. 201267   99. 10   0		OUTPATIENT SERVICE COST CENTERS					
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT   0. 405261   92. 00   OTHER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   0. 328462   95. 00   99. 10   09910   CORF   99. 10	90.00	09000 CLI NI C	0. 530014				90. 00
OTHER REI MBURSABLE COST CENTERS         95. 00         995.00 AMBULANCE SERVI CES         95. 00         99. 10         9991 CORF         99. 10	91.00	09100 EMERGENCY	0. 201267				91.00
95. 00   09500   AMBULANCE SERVI CES   0. 328462   95. 00   99. 10   09910   CORF   99. 10	92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 405261				92.00
99. 10   09910   CORF   99. 10		OTHER REIMBURSABLE COST CENTERS					
	95.00	09500 AMBULANCE SERVICES	0. 328462				95. 00
	99. 10	09910 CORF					99. 10
101. 00 10100 HOME HEALTH AGENCY   101. 00	101.00	10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS		SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE 113. 00	113.00	11300   NTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE 116. 00	116.00	11600 H0SPI CE					116.00
200.00 Subtotal (see instructions) 200.00	200.00	Subtotal (see instructions)					200.00
201. 00 Less Observation Beds 201. 00		,					
202.00 Total (see instructions) 202.00	202.00	Total (see instructions)					202.00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 15-0045	Peri od: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Pre 2/23/2017 4:5	
		Ti 1	tle XIX	Hospi tal	Cost	
				C+-		

				'	0 09/30/2016	2/23/2017 4:5	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 991, 773		5, 991, 773		5, 991, 773	
31.00	03100 INTENSIVE CARE UNIT	2, 466, 653		2, 466, 653	0	2, 466, 653	31. 00
43.00	04300 NURSERY	427, 629		427, 629	0	427, 629	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	4, 955, 052		4, 955, 052	2 0	4, 955, 052	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 689, 554		1, 689, 554		1, 689, 554	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 504, 589		4, 504, 589	0	4, 504, 589	54.00
60.00	06000 LABORATORY	4, 790, 737		4, 790, 737	0	4, 790, 737	60.00
60. 01	06001 BLOOD LABORATORY	0		(	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	948, 537	0	948, 537	0	948, 537	65.00
66.00	06600 PHYSI CAL THERAPY	2, 086, 936	0	2, 086, 936	0	2, 086, 936	66.00
66. 01	06601 CARDI AC REHAB	409, 509	0	409, 509	0	409, 509	66. 01
69.00	06900 ELECTROCARDI OLOGY	105, 675		105, 675	0	105, 675	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	105, 006		105, 006	0	105, 006	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	2, 503, 639		2, 503, 639	o	2, 503, 639	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 322, 180		1, 322, 180	o	1, 322, 180	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 347, 033		4, 347, 033	o o	4, 347, 033	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	88, 436		88, 436	0	88, 436	90.00
91.00	09100 EMERGENCY	3, 013, 040		3, 013, 040	o	3, 013, 040	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1, 389, 416		1, 389, 416		1, 389, 416	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 867, 025		1, 867, 025	0	1, 867, 025	95. 00
99. 10	09910 CORF	0		(		0	99. 10
101.00	10100 HOME HEALTH AGENCY	1, 644, 747		1, 644, 747	, l	1, 644, 747	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	367, 899		367, 899		367, 899	116. 00
200.00	Subtotal (see instructions)	45, 025, 065	0	45, 025, 065	0	45, 025, 065	200.00
201.00	Less Observation Beds	1, 389, 416		1, 389, 416	b	1, 389, 416	201.00
202.00	Total (see instructions)	43, 635, 649	0	43, 635, 649	o	43, 635, 649	202. 00
				•	. '		•

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0045	Peri od: Worksheet C From 10/01/2015 Part I To 09/30/2016 Date/Time Prepared:

				أ	To 09/30/2016	Date/Time Pre 2/23/2017 4:5	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	DOO ADULTS & PEDIATRICS	10, 922, 874		10, 922, 874			30. 00
	100 INTENSIVE CARE UNIT	4, 697, 421		4, 697, 421			31. 00
	300 NURSERY	874, 272		874, 272	2		43. 00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	4, 177, 194	15, 409, 312			0. 000000	
	200 DELIVERY ROOM & LABOR ROOM	1, 744, 940	6, 986			0. 000000	
	400 RADI OLOGY-DI AGNOSTI C	1, 801, 634	24, 004, 702			0. 000000	
	DOO LABORATORY	3, 371, 815	19, 902, 633	23, 274, 448		0. 000000	
	001 BLOOD LABORATORY	0	0	`		0. 000000	
	500 RESPI RATORY THERAPY	3, 737, 032	1, 145, 472			0. 000000	
	600 PHYSI CAL THERAPY	911, 895	4, 515, 261			0.000000	
	601 CARDI AC REHAB	3, 938	412, 677			0.000000	
	900 ELECTROCARDI OLOGY	226, 505	1, 143, 912			0.000000	
	DOO ELECTROENCEPHALOGRAPHY	0	1, 050, 748	1, 050, 748		0.000000	
	100 MEDICAL SUPPLIES CHARGED TO PAT	1, 767, 356	2, 808, 845	4, 576, 201		0.000000	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	3, 495, 947	1, 670, 935	5, 166, 882	0. 255895	0.000000	72. 00
	300 DRUGS CHARGED TO PATIENTS	2, 256, 529	4, 739, 682	6, 996, 21	0. 621341	0. 000000	73. 00
	TPATIENT SERVICE COST CENTERS						
90.00 090	DOO CLI NI C	130	166, 726	166, 856	0. 530014	0.000000	90. 00
91. 00   091	100 EMERGENCY	2, 430, 327	12, 540, 042	14, 970, 369	0. 201267	0.000000	91. 00
92. 00 092	200 OBSERVATION BEDS (NON-DISTINCT	0	3, 428, 447	3, 428, 447	0. 405261	0.000000	92. 00
	HER REIMBURSABLE COST CENTERS						
95. 00 095	500 AMBULANCE SERVICES	0	5, 684, 137	5, 684, 137	0. 328462	0.000000	95. 00
99. 10 099		0	0	(			99. 10
101. 00 101	100 HOME HEALTH AGENCY	0	1, 167, 558	1, 167, 558	3		101. 00
SPE	ECLAL PURPOSE COST CENTERS						
113. 00 113	300 INTEREST EXPENSE						113. 00
116. 00 116	600 HOSPI CE	42, 168	582, 734	624, 902	2		116. 00
200.00	Subtotal (see instructions)	42, 461, 977	100, 380, 809	142, 842, 786	5		200. 00
201.00	Less Observation Beds						201. 00
202. 00	Total (see instructions)	42, 461, 977	100, 380, 809	142, 842, 786	5		202. 00
		·			·		

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0045	Peri od: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Prep 2/23/2017 4:56	pared:
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					

			TI LIE XIX	HOSPI (ai	COST
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
I N	PATIENT ROUTINE SERVICE COST CENTERS				
30.00 03	000 ADULTS & PEDIATRICS				30. 00
31.00 03	100 INTENSIVE CARE UNIT				31.00
43.00 04	300 NURSERY				43. 00
	CILLARY SERVICE COST CENTERS				
	OOO OPERATING ROOM	0. 000000			50. 00
52.00 05	200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60.00 06	000 LABORATORY	0. 000000			60. 00
60. 01 06	001 BLOOD LABORATORY	0. 000000			60. 01
65. 00 06	500 RESPI RATORY THERAPY	0. 000000			65. 00
66.00 06	600 PHYSI CAL THERAPY	0. 000000			66. 00
66. 01 06	601 CARDI AC REHAB	0. 000000			66. 01
69.00 06	900 ELECTROCARDI OLOGY	0. 000000			69. 00
70.00 07	000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000			71. 00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OU.	TPATIENT SERVICE COST CENTERS				
90.00 09	000 CLI NI C	0. 000000			90. 00
91.00 09	100 EMERGENCY	0. 000000			91. 00
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT	0. 000000			92.00
	HER REIMBURSABLE COST CENTERS				
95. 00 09	500 AMBULANCE SERVICES	0. 000000			95. 00
99. 10 09					99. 10
101. 00 10	100 HOME HEALTH AGENCY				101. 00
	ECIAL PURPOSE COST CENTERS				
	300 INTEREST EXPENSE				113. 00
	600 HOSPI CE				116. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202. 00	Total (see instructions)				202. 00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 10/01/2015 To 09/30/2016		narod:
				10 09/30/2010	2/23/2017 4:5	
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	592, 437	C	592, 43	7 6, 473	91. 52	30. 00
31.00 INTENSIVE CARE UNIT	236, 545		236, 54	5 1, 490	158. 76	31.00
43. 00 NURSERY	40, 473		40, 47	3 860	47. 06	43.00
200.00 Total (lines 30-199)	869, 455		869, 45	5 8, 823		200. 00
Cost Center Description	I npati ent	Inpati ent		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 763	161, 350				30. 00
31.00 INTENSIVE CARE UNIT	461	73, 188	3			31.00
43. 00 NURSERY	0	l c				43.00
200.00 Total (lines 30-199)	2, 224	234, 538	3			200. 00

111-6-	Figure 1 Contact	DEIVALD MEMODI	AL HOCDITAL		1 - 11 -	£ F CMC :	2552 40
	Financial Systems	DEKALB MEMORI		ON 15 0045		eu of Form CMS-1	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L C0515	Provider Co		Peri od: From 10/01/2015	Worksheet D Part II	
					To 09/30/2016		pared:
						2/23/2017 4:5	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	_	,			,	
50. 00	05000 OPERATING ROOM	754, 054					
52.00	05200 DELIVERY ROOM & LABOR ROOM	540, 581					1
54.00	05400 RADI OLOGY-DI AGNOSTI C	429, 749					
60.00	06000 LABORATORY	249, 776	23, 274, 448			17, 219	
60. 01	06001 BLOOD LABORATORY	0	0	0.00000	0 0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	57, 171	4, 882, 504	0. 01170	1, 483, 887	17, 375	65. 00
66.00	06600 PHYSI CAL THERAPY	224, 075	5, 427, 156	0. 04128	388, 842	16, 055	66.00
66. 01	06601 CARDI AC REHAB	108, 672	416, 615	0. 26084	5 722	188	66. 01
69.00	06900 ELECTROCARDI OLOGY	2, 560	1, 370, 417	0. 00186	99, 988	187	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 488	1, 050, 748	0. 00236	8 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	82, 414	4, 576, 201	0. 01800	9 665, 110	11, 978	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 602	5, 166, 882	0. 00263	3 993, 898	2, 617	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	89, 711	6, 996, 211	0. 01282	907, 830	11, 641	73. 00
	OUTPATIENT SERVICE COST CENTERS		•	•		•	
90.00	09000 CLI NI C	1, 594	166, 856	0. 00955	3 0	0	90.00
91.00	09100 EMERGENCY	352, 773	14, 970, 369	0. 02356	5 956, 330	22, 536	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	137, 379	3, 428, 447	0. 04007	0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>				<u>'</u>	
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	3, 046, 599	118, 871, 622		9, 526, 667	165, 286	200. 00
		•		•		•	•

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provider Co		Period: From 10/01/2015 To 09/30/2016		
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	1	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	1	0	0	31.00
43. 00   04300 NURSERY	0	0	)	o	0	43.00
200.00 Total (lines 30-199)	0	0		O	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
		ŕ		Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8.00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 473	0.00	1, 76	3 0	,	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 490	0.00	46	1 0	,	31.00
43. 00   04300 NURSERY	860		)	o o	,	43.00
200.00 Total (lines 30-199)	8, 823	l .	2, 22	4 0		200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0045   Period: From 10/01/2015   Part I V Date/Time Prepared: 2/23/2017 4:56 pm   Period: 70 09/30/2016   Peri	Heal th	Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
Non Physician   Nursing School   Allied Health   All Other   Medical   Education Cost   Sum of col 1   through col .			VICE OTHER PAS	S Provider C		From 10/01/2015	Part IV Date/Time Pre	pared: 6 pm
Anesthetist   Cost   Education Cost   Cost   Cost   Education Cost   C				Titl∈	XVIII	Hospi tal	PPS	
1.00   2.00   3.00   4.00   5.00		Cost Center Description	Anesthetist	Nursing School	Allied Health	Medi cal	(sum of col 1 through col.	
ANCI LLARY SERVI CE COST CENTERS			1 00	2.00	2 00	4.00		
50.00   05000   0PERATING ROOM   0   0   0   0   0   0   0   0   0		ANCILLADY SEDVICE COST CENTEDS	1.00	2.00	3.00	4.00	5.00	
S2.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   52.00			0		l .	) 0	0	50 00
54. 00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0       54. 00         60. 00       06000       LABORATORY       0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td>· ·</td> <td></td>			0			0	· ·	
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0			0					
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 60. 01 65. 00 650. 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 65. 00 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 66. 00 66. 00 66. 01 06601 CARDI AC REHAB 0 0 0 0 0 0 0 0 0 66. 01 69. 00 06900 ELECTROCARDI 0LOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			0	_	
65. 00   06500   RESPIRATORY THERAPY   0 0 0 0 0 0 0 0 0 0 65. 00   66. 00   06600   PHYSI CAL THERAPY   0 0 0 0 0 0 0 0 0 0 66. 00   66. 01   06601   CARDI AC REHAB   0 0 0 0 0 0 0 0 0 0 0 66. 01   69. 00   06900   ELECTROCARDI OLOGY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			0	0	
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   66. 00   66. 01   06601   CARDI AC REHAB   0   0   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PAT   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   74. 00   07400   07400   07400   75. 00   07500   07500   07500   07500   76. 00   07500   07500   07500   07500   77. 00   07500   07500   07500   07500   78. 00   07500   07500   07500   0   79. 00   07500   07500   07500   0   79. 00   07500   07500   07500   0   79. 00   07500   07500   07500   0   79. 00   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   0   79. 00   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   07500   0   79. 00   07500   07500   07500   0   79. 00   07500   07500   07500   0   79. 00   07500   07500   07500			0	i o	,	0	0	
66. 01 06601 CARDI AC REHAB 0 0 0 0 0 0 0 0 66. 01 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00  OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT 0 0 0 0 0 0 0 0 92. 00  OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES			0	l o	,	0	0	
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   70. 00   71. 00	66. 01	06601 CARDI AC REHAB	0	o	,	0	0	
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PAT   0   0   0   0   0   0   71. 00   72. 00   72. 00   1MPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0	69. 00	06900 ELECTROCARDI OLOGY	0	0	,	0	0	69. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0    0UTPATIENT SERVICE COST CENTERS   0   0   0   0   0   0    91. 00   09100   EMERGENCY   0   0   0   0   0   0    92. 00   09200   OBSERVATION BEDS (NON-DISTINCT   0   0   0   0   0    0THER REIMBURSABLE COST CENTERS   95. 00    95. 00   09500   AMBULANCE SERVICES   95. 00	70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	,	0	0	70.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73. 00	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	o c	,	0 0	0	71. 00
OUTPATIENT SERVICE COST CENTERS     O	72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o c	1	0	0	72. 00
90. 00   09000   CLI NI C   0   0   0   0   0   0   0   0   0	73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	)	0 0	0	73. 00
91. 00   09100   EMERGENCY   0   0   0   0   0   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT   0   0   0   0   0   0   0   0   0		OUTPATIENT SERVICE COST CENTERS						
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT 0 0 0 0 0 0 92. 00   OTHER REI MBURSABLE COST CENTERS 95. 00   09500   AMBULANCE SERVI CES 95. 00	90. 00	09000 CLI NI C	0	C	)	0 0	0	90.00
OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00	09100 EMERGENCY	0	0	)	0 0	0	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
200 00	95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	200. 00	Total (lines 50-199)	0	0	)	0 0	0	200. 00

Heal th	Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10						
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider Co		Peri od:	Worksheet D	
THROUG	SH COSTS				From 10/01/2015 To 09/30/2016	Part IV Date/Time Pre	narodi
					10 09/30/2010	2/23/2017 4:5	
			Title	: XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of				Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS		T	T			
50. 00	05000 OPERATING ROOM	0	19, 586, 506			1, 096, 080	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 751, 926	•		3, 942	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	25, 806, 336			1, 325, 625	
60.00	06000 LABORATORY	0	23, 274, 448			1, 604, 413	
60. 01	06001 BLOOD LABORATORY	0	0	0. 00000		0	60. 01
65. 00	06500 RESPI RATORY THERAPY	0	4, 882, 504			1, 483, 887	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	5, 427, 156			388, 842	
66. 01	06601 CARDI AC REHAB	0	416, 615			722	66. 01
69. 00	06900 ELECTROCARDI OLOGY	0	1, 370, 417			99, 988	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	1, 050, 748			0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	4, 576, 201			665, 110	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	5, 166, 882			993, 898	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	6, 996, 211	0.00000	0. 000000	907, 830	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0				0	
91. 00	09100 EMERGENCY	0	14, 970, 369			956, 330	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	0	3, 428, 447	0.00000	0. 000000	0	92. 00
	OTHER REIMBURSABLE COST CENTERS		1	1			
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	118, 871, 622	l		9, 526, 667	200. 00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0045	From 10/01/2015	Worksheet D Part IV Date/Time Prepared:

						2/23/2017 4:5	6 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col. 9			
		x col. 10)		x col. 12)			
		11. 00	12.00	13. 00			
	ANCILLARY SERVICE COST CENTERS						4
50. 00	05000 OPERATI NG ROOM	0	2, 769, 432		D		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		D		52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 561, 173		D		54.00
60. 00	06000 LABORATORY	0	1, 825, 680		D		60.00
60. 01	06001 BLOOD LABORATORY	0	0		O		60. 01
65.00	06500 RESPI RATORY THERAPY	0	192, 193		O		65. 00
66.00	06600 PHYSI CAL THERAPY	0	24, 752		O		66. 00
66. 01	06601 CARDI AC REHAB	0	165, 640		O		66. 01
69. 00	06900 ELECTROCARDI OLOGY	0	276, 503		O		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	227, 070		O		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	352, 543		O		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	178, 251		O		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 295, 446	(	O		73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		O		90.00
91.00	09100 EMERGENCY	0	1, 988, 267		O		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	800, 360	(	O		92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		·			·	95. 00
200.00	Total (lines 50-199)	0	14, 657, 310				200. 00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0045		Worksheet D
			From 10/01/2015	Part V

	TOWNER OF MEDICAL, OTHER HEALTH SERVICES AND	VACOTIVE COST		F	rom 10/01/2015 o 09/30/2016	Part V Date/Time Pre 2/23/2017 4:5	
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0. 252983	2, 769, 432	C	0	700, 619	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 964398	0	C	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 174554	4, 561, 173		0	796, 171	54.00
60.00	06000 LABORATORY	0. 205837	1, 825, 680	1, 982	0	375, 792	60.00
60. 01	06001 BLOOD LABORATORY	0.000000	0	C	0	0	60. 01
65. 00	06500 RESPIRATORY THERAPY	0. 194273	192, 193	C	0	37, 338	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 384536	24, 752	C	0	9, 518	66.00
66. 01	06601 CARDI AC REHAB	0. 982943	165, 640	C	o	162, 815	66. 01
69.00	06900 ELECTROCARDI OLOGY	0. 077112	276, 503	l	o	21, 322	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 099935	227, 070		o	22, 692	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 547100	352, 543		o	192, 876	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 255895	178, 251		o	45, 614	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 621341	1, 295, 446	ď	20, 692		
	OUTPATIENT SERVICE COST CENTERS		, , , , , , ,				
90.00	09000 CLI NI C	0. 530014	0	C	0	0	90.00
91.00	09100 EMERGENCY	0. 201267	1, 988, 267	d	o	400, 173	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 405261	800, 360		o	324, 355	1
	OTHER REIMBURSABLE COST CENTERS		222,222	<u>-</u>	-1		1
95. 00	09500 AMBULANCE SERVI CES	0. 328462		C			95. 00
200.00			14, 657, 310	1, 982	20, 692	3, 894, 199	200.00
201.00	1 1		, ,	.,	0	2, 21 1, 111	201. 00
	Only Charges			]			
202.00			14, 657, 310	1, 982	20, 692	3, 894, 199	202. 00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	AND VACCINE COST	Provider Co	CN: 15-0045	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part V Date/Time Prep 2/23/2017 4:50	pared: 6 pm
		Title	XVIII	Hospi tal	PPS	
	Co	sts				
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
	Servi ces Subj ect To	Services Not Subject To				
	Ded. & Coins. (see inst.)	Ded. & Coins. (see inst.)				
	4 00	7.00	1			l .

	cost center bescription	COST	l cost l	
		Rei mbursed	Rei mbursed	
		Servi ces	Services Not	
		Subject To	Subject To	
		Ded. & Coins.	Ded. & Coins.	
		(see inst.)	(see inst.)	
		6. 00	7.00	
	ANCILLARY SERVICE COST CENTERS			
50.	05000 OPERATING ROOM	0	0	50. 00
52.	00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.	00 05400 RADI OLOGY-DI AGNOSTI C	0	0	54.00
60.	00 06000 LABORATORY	408	0	60.00
60.	01 06001 BLOOD LABORATORY	0	0	60. 01
65.	00 06500 RESPIRATORY THERAPY	0	o	65. 00
66.	00 06600 PHYSI CAL THERAPY	0	o	66. 00
66.	01 06601 CARDI AC REHAB	0	o	66. 01
69.	00 06900 ELECTROCARDI OLOGY	0	o	69. 00
70.	00 07000 ELECTROENCEPHALOGRAPHY	0	ol	70. 00
71.	00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	ol	71. 00
72.	00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	ol	72. 00
73.	00 07300 DRUGS CHARGED TO PATIENTS	0	12, 857	73. 00
	OUTPATIENT SERVICE COST CENTERS			
90.	00 09000 CLI NI C	0	0	90.00
91.	00 09100 EMERGENCY	0	o	91.00
92.	00 09200 OBSERVATION BEDS (NON-DISTINCT	0	o	92.00
	OTHER REIMBURSABLE COST CENTERS			
95.	00 09500 AMBULANCE SERVICES	0		95. 00
200	00 Subtotal (see instructions)	408	12, 857	200. 00
201	00 Less PBP Clinic Lab. Services-Program	0		201.00
	Only Charges			
202	Net Charges (line 200 +/- line 201)	408	12, 857	202. 00
		1		•

Health Financial Systems	DEKALB MEMORIAL HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	P	Provider CCN:	15-0045	Peri od: From 10/01/2015	Worksheet D-1	
				To 09/30/2016	Date/Time Prep 2/23/2017 4:50	
		Title XV	Ш	Hospi tal	PPS	
Cost Center Description						

		Title XVIII	Hospi tal	PPS	э ріп
	Cost Center Description				
	DATE AND DROWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		6, 473	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			6, 473	
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3.00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room		21 of the cost	4, 972 0	4. 00 5. 00
5.00	reporting period	olii days) tili odgir becelliber	31 Of the Cost	U	5.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	adys) arter becomber or	or the cost	G	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 763	9. 00
40.00	newborn days)			0	40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructions)		om days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		om davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	( only (including private	room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	/ only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			U	13.00
14.00	Medically necessary private room days applicable to the Progra			0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 of	the cost	0.00	17. 00
17.00	reporting period	es thi ough becember 31 of	the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	e cost	0.00	20. 00
	reporting period			2.22	
21. 00	Total general inpatient routine service cost (see instructions			5, 991, 773	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)	or or one court reper entry		_	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line	0	24. 00
25 00	7 x line 19)	21 of the cost reporting	noriad (line 0	0	25. 00
25. 00	Swing-bed cost applicable to NF type services after December 3   x line 20)	or the cost reporting	period (iine 8	U	25.00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 991, 773	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		<u>,                                     </u>	-	00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	rges)	0	28. 00 29. 00
30. 00	Semi -private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	aug line 22) (cas instruct	i ana)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		i ons)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	10 01)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost dif	ferential (line	5, 991, 773	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			925. 66	38. 00
39. 00	Program general inpatient routine service cost per dreim (see			1, 631, 939	
40.00	Medically necessary private room cost applicable to the Progra			0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 631, 939	41. 00

Provider COR: 15 COAT   Severice (1997)   Provider COAT   Severice (1997)   Provid	Heal th	n Financial Systems DEKALB MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2	<u> 2552-10</u>
To 09/30/2016   Color   Colo	COMPUT		1/2015		
Dest Center Description				Date/Time Pre	
Inpatient Cost Impatient Cost Inpatient (coil. 1 -   coil. 2   x coil. 3   x		Title XVIII Hospit	al		о рііі
1.00   1.00   2.00   3.00   4.00   5.00   0.00			Days		
1.00   2.00   3.00   4.00   5.00   0   0.42.00   0.00   0   0.42.00   0.00   0   0.42.00   0.00   0   0.42.00   0.00   0   0.42.00   0.00   0   0.00   0   0.00   0   0					
Interest vol Care Type   Input ent Hospital Unit vs.   2, 466, 663   1, 490   1, 665, 47   461   763, 172   43, 00   MINESTRUCTURE CALL (MIT   1, 400   1,		1.00 2.00 3.00 4.00		5. 00	
	42. 00		0	0	42.00
45.00   SIBRIA INTENSIVE CARE UNIT	43.00		461	763, 172	43. 00
3.00   Cost Center Description					
47.00   OTHER SPECIAL CARE (SPECIFY)   47.00					
1.00	47. 00	OTHER SPECIAL CARE (SPECIFY)			•
		Cost Center Description		1 00	
PASS TRIBUICH COST ADJUSTNENTS					48. 00
50.00   Pass through costs applicable to Program inpatient routine services (From Wisst. D., sum of Parts I and 17)   Pass through costs applicable to Program inpatient and Illary services (From Wisst. D., sum of Parts II   165, 286   51.00   1	49. 00			5, 058, 833	49. 00
15.00   Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II   165, 266   51, 00   and IPOgram excludable cost (sum of lines 50 and 51)   399, 824   52, 00   390, 824   52, 00	50. 00		I and	234, 538	50. 00
and IV)  10.00 Total Program excludable cost (sum of lines 50 and 51) 10.00 Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and discount octs. (line 49 minus line 52) 10.00 Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and discount octs. (line 49 minus line 52) 10.00 Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and discount octs. (line 49 minus line 52) 10.00 Total Program discharges 10.00 Discount octs. (line 49 minus line 52) 10.00 Total Program discharges 10.00 Discount octs. (line 49 minus line 52) 10.00 Discount octs. (line 53 minus line 53) 10.00 Discount octs. (line 53 minus line 54 minus line 54 minus line 53) 10.00 Discount octs. (line 53 minus line 54 minus line 55 minus lin	E4 00			1/5 00/	F4 00
Total Program excludable cost (sun of lines 50 and 51)   39, 824   52.00   53.00   Total Program instant operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 sinus line 52)   A,659,009   53.00   TARSET MOUNT AND LINE COMPUTATION	51.00		SII	165, 286	51.00
medical education costs (line 4º minus line 52)		Total Program excludable cost (sum of lines 50 and 51)			
TARGET MOUNT AND LIMIT COMPUTATION   54.00   84.00   75.00   14   10   10   10   10   10   10	53. 00		I	4, 659, 009	53. 00
55.00   Target amount per discharge   0.00   55.00   0.50   0.00   55.00   0.					
56.00   Target amount (line 54 x line 55)   0.56.00   56.00   57.00   0.57.00   0.57.00   0.57.00   0.57.00   0.57.00   0.58.00   0.57.00   0.58.00   0.59					
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 58.00 Box payment (see instructions) 0 58.00 clesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 60.00 clesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 60.00 clesser of lines 53/54 is less than the lower of lines 55,59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 63.00 allowable inpatient cost plus incentive payment (see instructions) 0 63.00 allowable inpatient cost plus incentive payment (see instructions) 0 63.00 allowable inpatient cost plus incentive payment (see instructions) 0 64.00 closed care swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (ititle XVIII only) 66.00 box closed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (ititle XVIII only) 66.00 closed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 0 66.00 closed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 0 66.00 closed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (line 12 x line 19) (see instructions) (line 13 x line 20) (see instructions) (line 3 x line 20) (see instructions) (line 3 x line 20) (see instructions) (line 3 x line 20) (see instructions) (see instructions) (line 3 x line 20) (see instructions) (see ins					
59.00   Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   60.00   Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket   0.00   60.00   60.00   11 line 53/54 is less than the lower of lines 55,59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target   0.00   60	57. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		0	57. 00
market basket  0.00 00.00  61.00 If line \$3.754 is less than the lower of lines \$5, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line \$3 are less than expected costs (lines \$4 x 60), or 1% of the amount by which operating costs (line \$3) are less than expected costs (lines \$4 x 60), or 1% of the target amount (line \$6), otherwise enter zero (see instructions)  8.00 All owable Inpartient (see instructions)  8.00 All owable Inpartient cost plus incentive payment (see instructions)  8.00 All owable Inpartient cost plus incentive payment (see instructions)  8.00 All owable Inpartient cost plus incentive payment (see instructions)  8.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  8.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  8.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Octal Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only).  8.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only).  9.00 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Octal Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only).  9.00 Total Medicare swing-bed NF inpatient routine costs (line 67 + line 68)  9.00 Total stitle V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9.01 Total title V or XIX swing-bed NF inpatient routine service cost (line 70 + line 70)  9.01 Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 70)  9.01 T			w tho		
1.00   If line 53/54 is less than the lower of lines 55, 50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	34.00		y the	0.00	39.00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  Relief payment (see instructions) (title XVIII only)  Relief payment (see instructions)  Relief payment			· b		
California   Cal	61.00				61.00
Allowable Inpatient cost plus incentive payment (see instructions)   PROGRAM INPATIENT ROUTINE SWING BED COST	(0.00	amount (line 56), otherwise enter zero (see instructions)			
PROGRAM INPATIENT ROUTINE SWING BED COST  4. 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)  65. 00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)  66. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Compare the first of the cost reporting period (See Instructions)  67. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Compare the first of the cost reporting period (See Instructions)  67. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Ine 12 x Iine 19)  68. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Ine 13 x Iine 20)  69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69. 00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37)  70. 00 Adjusted general inpatient routine service cost (Ine 70 + line 2)  71. 00 Adjusted general inpatient routine service cost per diem (Ine 70 + line 2)  72. 00 Total Program general inpatient routine service costs (Ine 72 + line 73)  73. 00 Medically necessary private room cost applicable to Program (line 14 x Iine 73)  74. 00 Total Program general inpatient routine service costs (From Worksheet B, Part II, column 26, line 45)  75. 00 Capital -related costs (line 75 + line 2)  76. 00 Per diem capital -related costs (line 75 + line 2)  77. 00 Aggregate charges to benefic laries for excess costs (from provider records)  80. 00 Total Program routine service costs (see instructions)  81. 00 Agusted general inpatient routine service costs (see instructions)  82. 00 Inpatient routine service cost (line 9 x line 71)  83. 00 Total December of the program in pa					
instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)  65.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See instructions)  67.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 20)  69.00 Total itile V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID DNLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Total Program general inpatient routine service costs (line 72 + line 73)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Copital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Program capital -related costs (line 75 + line 2)  77.00 Program capital -related costs (line 9 x line 77)  78.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  80.00 Total Program routine service costs (see instructions)  81.00 Inpatient routine service cost (see instructions)  82.00 Inpatient routine service cost (see instructions)  83.00 Reasonable inpatient ancillary services (see instructions)  84.00 Program inpatient ancillary services (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utili Program inpatient operating costs (see instructions)  86.00 Total Program inpatient oper		PROGRAM INPATIENT ROUTINE SWING BED COST			
65.00   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)   66.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see Instructions)   67.00   Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)   68.00   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)   69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   0 of 69.00   69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   0 of 69.00   69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   0 of 69.00   69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   0 of 69.00   69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   0 of 69.00   69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   0 of 69.00   69.00   Total title V or XIX swing-bed NF inpatient routine service cost (line 37)   70.00   70.00   Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)   70.00   71.00   Program routine service cost (line 9 x line 71)   72.00   72.00   73.00   73.00   74	64. 00		(See	0	64. 00
66.00 Total Medicaire swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related cost (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost film limitation 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost limitation (line 78 minus line 79) 79.01 Inpatient routine service cost signed inpatient routines service cost (see instructions) 79.02 Utilization review - physician compensation (see instructions) 79.01 Utilization review - physician compensation (see instructions) 79.02 Otal Program inpatient ancillary services (see instructions) 79.03 Utilization review - physician compensation (see instructions) 79.04 Adjusted general inpatient routine cost per diem (line 27 + line 2) 70.07 Otal Program inpatient poerating osts (sum of lines 83 through 85) 70.08 Adjusted general inpatient routine cost per diem (line 27 + line 2) 70.09 Otal Program inpatient routine cost per diem (line 27 + line 2) 70.09 Otal Program	65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (\$	See	0	65. 00
CAH (see instructions)  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Program general inpatient routine service costs (line 72 + line 73)  73.00 Modically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 74 minus line 77)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)  80.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost (see instructions)  82.00 Inpatient routine service cost (see instructions)  83.00 Reasonable inpatient routine service cost (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  925.66 88.00	66 00		or		66 00
(line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital -related costs (line 75 + line 2)  77.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs (line 74 minus line 77)  80.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost (see instructions)  83.00 Reasonable inpatient operating costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	00.00		OI .		00.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related costs (line 75 + line 2) 76.00 Per diem capital-related costs (line 9 x line 76) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Program capital-related costs (line 74 minus line 77) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost per diem limitation (line 78 minus line 79) 80.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service (see instructions) 83.00 Reasonable inpatient routine service (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Ultilization review - physician compensation (see instructions) 85.00 Ultilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	67. 00		eri od	0	67. 00
Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	68. 00		od	0	68. 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  78.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Weasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  70.00 POSS Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  71.00 POSS Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  925.66	(0.00				40.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 78 + line 2) 77.00 Program capital-related costs (line 74 minus line 77) 8.00 Inpatient routine service cost (line 74 minus line 77) 8.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Reasonable inpatient routine services (see instructions) 82.00 Measonable inpatient routine service costs (see instructions) 83.00 Utilization review - physician compensation (see instructions) 84.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  85.00 Adjusted general inpatient routine service instructions) 925.66 88.00	09.00			. 0	09.00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.01 Inpatient routine service cost per diem limitation 79.02 Inpatient routine service cost limitation (line 9 x line 81) 79.00 Reasonable inpatient routine service costs (see instructions) 79.00 Reasonable inpatient ancillary services (see instructions) 79.00 Reasonable inpatient ancillary services (see instructions) 79.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 79.00 Program inpatient operating costs (sum of lines 83 through 85) 79.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 79.00 Reasonable inpatient routine bed days (see instructions) 79.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 79.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 79.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 79.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 79.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2)					•
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  925.66 88.00					•
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  925.66 88.00	73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)			73. 00
26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			d ump		
77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  78.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  80.00 Inpatient routine service cost per diem limitation  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Possible records)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Program capital records (line 74 minus line 77)  88.00 Adjusted general inpatient cost per diem (line 27 ÷ line 2)	75.00		n ullin		75.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  78.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  78.00 Total observation bed days (see instructions)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Program inpatient ancillary services (see instructions)  84.00 Utilization review - physician compensation (see instructions)  85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 POSS THROUGH COST  1,501 POSS R8.00					
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Page 10 Page		Aggregate charges to beneficiaries for excess costs (from provider records)			79. 00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			")		•
84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Program inpatient ancillary services (see instructions)  88.00 Bed. 00  88.00 Porgram inpatient ancillary services (see instructions)  88.00 Bed. 00  88.00 Porgram inpatient ancillary services (see instructions)  88.00 Program inpatient ancillary services (see instructions)  89.00 Program inpatient ancillary service					
85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					•
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					
87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  1,501 87.00 925.66 88.00		Total Program inpatient operating costs (sum of lines 83 through 85)			•
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 925.66 88.00	87 NO			1 501	87 00
89.00   Observation bed cost (line 87 x line 88) (see instructions)   1,389,416   89.00	88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		925. 66	88. 00
	89. 00	Observation bed cost (line 87 x line 88) (see instructions)		1, 389, 416	89. 00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2015 To 09/30/2016	Date/Time Prep 2/23/2017 4:50	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	592, 437	5, 991, 773	0. 09887	5 1, 389, 416	137, 379	90.00
91.00 Nursing School cost	0	5, 991, 773	0.00000	0 1, 389, 416	0	91.00
92.00 Allied health cost	0	5, 991, 773	0.00000	0 1, 389, 416	0	92.00
93.00 All other Medical Education	0	5, 991, 773	0. 00000	1, 389, 416	0	93. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der (	CCN: 15-0045	Peri od: From 10/01/2015	Worksheet D-1	
				Date/Time Pre 2/23/2017 4:5	
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description					

		Title XIX	Hospi tal	Cost	o piii
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			6, 473	1
2.00	Inpatient days (including private room days, excluding swing-beneficially		luata maam daya	6, 473	1
3.00	do not complete this line.	ys). IT you have only pri	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		4, 972	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December (	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becember .	or the cost	U	0.00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
0.00	reporting period		1 -6	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	ii days) ai ter beceiiber 3	i or the cost	0	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	267	9. 00
40.00	newborn days)				1.0.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, er				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	X only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	X only (including private	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e) ,		10.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			860	1
10.00	SWING BED ADJUSTMENT			0	10.00
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost	0.00	17. 00
40.00	reporting period				1000
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of 1	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19.00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	he cost	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		5, 991, 773	21.00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	1
22.00	5 x line 17)	21 -6 +1++		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December $x$ line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reportin	ng period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December $3 \times 1$ ine $20$ )	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		5, 991, 773	27. 00
00.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			-	
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0	28. 00 29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	ŕ		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x lin		•	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	1
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	5, 991, 773	1
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			1
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			925. 66	38.00
	Adjusted general inpatient routine service cost per diem (see				1
	Program general innations routing convice cost (line 0 v line				
39. 00	Program general inpatient routine service cost (line 9 x line	,		247, 151	1
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39)	am (line 14 x line 35)		247, 151 0 247, 151	40.00

	Financial Systems	DEKALB MEMORI		ON 45 CO.5		u of Form CMS-				
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 10/01/2015	Worksheet D-1				
					To 09/30/2016	Date/Time Pre 2/23/2017 4:5				
				e XIX	Hospi tal	Cost				
	Cost Center Description	Total	Total Inpatient Days	Average Per	Program Days	Program Cost (col. 3 x col.				
		Impatrent cost	Impatrent bays	col . 2)		4)				
12.00	NUDCEDY (+: +I - V 0 VIVI)	1.00	2.00	3.00	4. 00	5. 00	12.00			
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	427, 629	860	497. 2	24 0		42. 00			
43. 00	INTENSIVE CARE UNIT	2, 466, 653	1, 490	1, 655. 4	7 0	C	43. 00			
44. 00	CORONARY CARE UNIT						44. 00			
45. 00 46. 00							45. 00 46. 00			
	OTHER SPECIAL CARE (SPECIFY)						47. 00			
	Cost Center Description					1. 00				
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3. line 200)			213, 415	48. 00			
	Total Program inpatient costs (sum of lines		460, 566							
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp.	ationt routing	corvi cos (from	Wks+ D sum	of Dorts L and		50.00			
50.00	[111]	atrent routine	Services (IIIII	I WKSt. D, Suii	I OI PAILS I AIIU		30.00			
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	O	51. 00			
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00			
53. 00	Total Program inpatient operating cost exclu	ding capital re	elated, non-phy	sician anesth	etist, and	Ö				
	medical education costs (line 49 minus line	52)								
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00			
	Target amount per discharge					0.00	55. 00			
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	argot amount (1	ino E4 minus	lino E2)	0	56. 00 57. 00			
58. 00	Bonus payment (see instructions)	ing cost and ta	irget amount (i	THE SO IIITHUS	111le 53)					
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	pdated and co	mpounded by the	0. 00	59. 00			
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report ur	ndated by the m	arket hasket		0.00	60.00			
61. 00	If line 53/54 is less than the lower of line				the amount by	0.00	1			
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target									
62. 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)									
63. 00	O	63.00								
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doco	mbor 21 of the	cost roporti	ng poriod (Soo		64. 00			
04.00	instructions) (title XVIII only)	ts through bece	siliber 31 of the	cost reporti	ng perrou (see		04.00			
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00			
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	o	66. 00			
	CAH (see instructions)	·	·		3.					
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	n December 31 d	of the cost re	porting period	O	67. 00			
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after [	ecember 31 of	the cost repo	rting period	o	68. 00			
40.00	(line 13 x line 20)	routing costs (	lino 47 : lino	. 40)			69. 00			
09.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						09.00			
70. 00	Skilled nursing facility/other nursing facil						70. 00			
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00			
73. 00	Medically necessary private room cost applications		n (line 14 x li	ne 35)			73. 00			
74.00	Total Program general inpatient routine serv	•					74. 00			
75. 00	Capital-related cost allocated to inpatient   26. line 45)	routine service	e costs (from W	orksheet B, F	art II, column		75. 00			
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00			
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00			
79. 00	Aggregate charges to beneficiaries for exces	,	rovi der record	ls)			79.00			
80. 00	Total Program routine service costs for comp	us line 79)		80.00						
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		81. 00 82. 00							
83. 00										
84. 00	.00 Program inpatient ancillary services (see instructions)									
85. 00 86. 00										
55.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		Jugii 00 <i>)</i>				86.00			
87. 00	Total observation bed days (see instructions	)	Li 0)			1, 501	1			
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•					88.00			
_ /. 50	Observation bed cost (line 87 x line 88) (see instructions) 1,389,416 89.00									

Health Financial Systems	DEKALB MEMORIAL HOSPITAL In Lieu of Form C			u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
				From 10/01/2015 To 09/30/2016	Date/Time Prep 2/23/2017 4:50	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH C	OST					
90.00 Capital -related cost	592, 437	5, 991, 773	0. 09887	5 1, 389, 416	137, 379	90.00
91.00 Nursing School cost	0	5, 991, 773	0.00000	0 1, 389, 416	0	91. 00
92.00 Allied health cost	0	5, 991, 773	0.00000	0 1, 389, 416	0	92. 00
93.00 All other Medical Education	0	5, 991, 773	0. 00000	0 1, 389, 416	0	93. 00

NPATI ENT ANCILLARY SERVICE COST APPORTIONMENT	Heal th	Financial Systems DEKAL	B MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
To   O9/30/2016   Date/Time Prepared: 2/32/2017 4:56 pm     Title XVIII   Hospital   PPS     To Charges   Ratio of Cost   Inpatient Program Charges   PPS     To Charges   PPS     To Charges   PPS   PPS     To Charges   PPS     To Ch					Peri od:		
Ti ti e XVI I   Hospi tal   PPS							
INPATI ENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00			Ti tl e	XVIII	Hospi tal		
INPATI ENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00		Cost Center Description		Ratio of Cos			
INPATI ENT ROUTINE SERVICE COST CENTERS   3, 831, 179   30, 00   3000   ADULTS & PEDI ATRICS   1, 529, 058   31, 00   43, 00   4300   NURSERY   43, 00   40, 4000   40, 4000   40, 4000   40, 4000   40, 4000   40, 4000   40, 4000   40, 4000   40, 4000   40, 4000   40, 4000   40, 40, 40, 40, 40, 40, 40, 40, 40, 40,				To Charges			
INPATI ENT ROUTI NE SERVI CE COST CENTERS   3.831, 179   30.00   3.00					Charges		
INPATI ENT ROUTINE SERVICE COST CENTERS   3,831,179   30.00   30.00   3000  ADULTS & PEDI ATRI CS   1,529,058   31.00   31.0				1.00	2.00		
30.00   30.00   ADULTS & PEDIATRICS   3, 831, 179   1, 529, 058   31, 00   0310   INTENSIVE CARE UNIT   1, 529, 058   31, 00   0310   INTENSIVE CARE UNIT   1, 529, 058   31, 00   0310   ODE   0310		INDATIENT DOUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
31. 00   03100   NTENSIVE CARE UNIT   1,529,058   31. 00   04300   NURSERY   33. 00   04300   NURSERY   34. 00   04300   NURSERY   34. 00   04300   NURSERY   34. 00   050000   05000   050000   05000   050000   050000   050000	30 00			I	3 931 170		30 00
43.00							
NCILLARY SERVICE COST CENTERS					1, 327, 030		
50. 00   05000   OPERATING ROOM   0.252983   1,096,080   277,290   50. 00   52. 00   05200   DELI VERY ROOM & LABOR ROOM   0.964398   3,942   3,802   52. 00   05.00   05400   RADIO LOGY-DI AGROSTI C   0.174554   1,325,625   231,393   54. 00   06. 00   06. 00   LABORATORY   0.205837   1,604,413   330,248   60. 00   06. 00   07. 00	.0.00			1			10.00
54. 00       05400 RADI OLOGY-DI AGNOSTI C       0.174554       1, 325, 625       231, 393       54. 00         60. 00       06000 LABORATORY       0.205837       1, 604, 413       330, 248       60. 00         60. 01       06001 BLOOD LABORATORY       0.000000       0       0       60. 01         65. 00       06500 RESPI RATORY THERAPY       0.194273       1, 483, 887       288, 279       65. 00         66. 01       06601 CARDI AC REHAB       0.982943       722       710       66. 01         69. 00       06900 ELECTROCARDI OLOGY       0.077112       99, 988       7, 710       69. 00         70. 00       07000 DIABORATORY       0.099935       0       0       70. 00         70. 00       07100 MEDI CAL SUPPLIES CHARGED TO PAT       0.547100       665, 110       363, 882       71. 00         73. 00       07200 IMPL. DEV. CHARGED TO PATI ENTS       0.547100       665, 110       363, 882       71. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0.621341       907, 830       564, 072       73. 00         90. 00       09000 CLI NI C       0.530014       0       0       0       90.00         95. 00       09200 OBSERVATI ON BEDS (NON-DI STI NCT       0.405261       0	50.00			0. 25298	1, 096, 080	277, 290	50.00
60. 00	52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 96439	3, 942	3, 802	52. 00
60. 01   06001   06001   06001   06001   06001   06001   060000   060000   060000   060000   06000   06000   06000   060000   060000   060000   060000   060	54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 17455	1, 325, 625	231, 393	54.00
65. 00	60.00	06000 LABORATORY		0. 20583	1, 604, 413	330, 248	60.00
66. 00							
66. 01   06601   CARDI AC REHAB   0.982943   722   710   66. 01							
69. 00							
70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 099935   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PAT   0. 547100   665, 110   363, 882   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 255895   993, 898   254, 334   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 621341   907, 830   564, 072   73. 00   0000   CLI NI C   0. 530014   0   0   0   0   0   0   0   0   0							
71. 00						· ·	
72. 00							
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 621341   907, 830   564, 072   73. 00				1			
90. 00   091. 00   091. 00   092. 00   095. 00				1			
90. 00   09000   CLINIC   0. 530014   0   0   0   90. 00   09100   EMERGENCY   0. 201267   956, 330   192, 478   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT   0. 405261   0   0   92. 00   09500   AMBULANCE SERVICES   95. 00   200. 00   Color of the	/3.00			0.62132	907, 830	564, 072	/3.00
91. 00   09100   EMERGENCY   0. 201267   956, 330   192, 478   91. 00   09200   0BSERVATION BEDS (NON-DISTINCT   0. 405261   0   0   92. 00   00   00   00   00   00   00   00	00 00			0 52001	4	0	00.00
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT 0.405261 0 0 0 92. 00							
OTHER REIMBURSABLE COST CENTERS   95. 00   O9500   AMBULANCE SERVICES   95. 00   O0   O0   O0   O0   O0   O0   O0							1
95. 00	72.00			0. 40320	0		72.00
200.00 Total (sum of lines 50-94 and 96-98) 9,526,667 2,663,722 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	95. 00						95. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00					9, 526, 667	2, 663, 722	
			nly charges (line 61)		0		
	202.00		,		9, 526, 667		202. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0045	Peri od:	Worksheet D-3	
			From 10/01/2015 To 09/30/2016	Date/Time Pre	narod:
			10 09/30/2010	2/23/2017 4:5	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INDATI ENT. DOUTINE CEDVI CE COCT CENTEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS			242, 161	I	30.00
31. 00   03100   NTENSI VE CARE UNI T			231, 758		31.00
43. 00   04300   NURSERY			302, 371		43.00
ANCILLARY SERVICE COST CENTERS		1	302, 371	l	+3.00
50. 00 05000 OPERATING ROOM		0. 25298	33 52, 613	13, 310	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 96439			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1745	38, 287	6, 683	54.00
60. 00   06000   LABORATORY		0. 20583	37 201, 323	41, 440	60.00
60. 01   06001   BLOOD LABORATORY		0.00000	00	0	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 1942	73 178, 362		
66. 00   06600   PHYSI CAL THERAPY		0. 38453			
66. 01   06601   CARDI AC   REHAB		0. 98294			66. 01
69. 00 06900 ELECTROCARDI OLOGY		0. 0771			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 09993		1	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 54710			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 25589			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 62134	41 76, 713	47, 665	73. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC		0. 5300	14 0	0	90.00
91. 00   09100   EMERGENCY		0. 5300		_	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT		0. 20120	· ·		
OTHER REIMBURSABLE COST CENTERS		0.40520	0 0		92.00
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50-94 and 96-98)			679, 951	213, 415	
201.00 Less PBP Clinic Laboratory Services-Prog	ram only charges (line 61)		0,7,701		201. 00
202.00 Net Charges (line 200 minus line 201)	j s.ia. gos (11.10 01)		679, 951		202. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0	0045   Peri od:   Worksheet E From 10/01/2015   Part A To 09/30/2016   Date/Time Prepared: 2/23/2017 4:56 pm

			10 09/30/2010	2/23/2017 4:5	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (s	see	0	1. 01
1 02	instructions)	ng on or after October 1	(600	2 420 270	1 02
1. 02	DRG amounts other than outlier payments for discharges occurri instructions)	ng on or arter october	(See	3, 438, 370	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring r	orior to October	0	1. 03
1.05	1 (see instructions)	or to october	O	1.05	
1.04	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring o	on or after	0	1. 04
	October 1 (see instructions)	3 3			
2.00	Outlier payments for discharges. (see instructions)			3, 172	2. 00
2.01	Outlier reconciliation amount			0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
3.00	Managed Care Simulated Payments			0	3. 00
4.00	Bed days available divided by number of days in the cost report	rting period (see instruc	ctions)	51. 90	4. 00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most	t recent cost reporting p	period ending on	0. 00	5. 00
	or before 12/31/1996. (see instructions)			0.00	, 00
6. 00	FTE count for allopathic and osteopathic programs which meet if for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-d	on to the cap	0. 00	6. 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified u	under 42 CED 8412 105(f)	(1) (i v) (P) (1)	0. 00	7. 00
7. 00	ACA Section 5503 reduction amount to the IME cap as specified	under 42 CFR 8412.105(1)	(1)(IV)(B)(I) (1)(IV)(B)(2)	0.00	7. 00
7.01	If the cost report straddles July 1, 2011 then see instruction		(1)(17)(0)(2)	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for all opar		rams for	0. 00	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.		, I	0.00	0.00
	1998), and 67 FR 50069 (August 1, 2002).				
8. 01	The amount of increase if the hospital was awarded FTE cap slo	0.00	8. 01		
	the cost report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slo	ng hospital	0. 00	8. 02	
	under section 5506 of ACA. (see instructions)				
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (s	see	0. 00	9. 00
	instructions)				40.00
10.00	FTE count for allopathic and osteopathic programs in the curre	ent year trom your record	IS		10.00
11.00	FTE count for residents in dental and podiatric programs.				11. 00
12. 00 13. 00	Current year allowable FTE (see instructions)				12. 00 13. 00
14. 00	Total allowable FTE count for the prior year.  Total allowable FTE count for the penultimate year if that year.	ar anded on or after Sent	ombor 20 1007	0.00	
14.00	otherwise enter zero.	ar ended on or arter sept	.ellibet 30, 1997,	0.00	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18. 00	Adjusted rolling average FTE count				18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4)	).		0.000000	19. 00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21. 00
22.00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
	Indirect Medical Education Adjustment for the Add-on for Secti				
23. 00	Number of additional allopathic and osteopathic IME FTE reside	ent cap slots under 42 Se	ec. 412.105	0. 00	23. 00
	(f)(1)(iv)(C).				
24. 00	IME FTE Resident Count Over Cap (see instructions)				24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the I	ower of line 23 or line	24 (see	0.00	25. 00
24 00	instructions)  Desident to had ratio (divide line 25 by line 4)			0.000000	24 00
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4)  IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	
28. 00	IME add-on adjustment amount (see instructions)			0.000000	
28. 01	IME add-on adjustment amount (see instructions)	0			
29. 00	Total IME payment ( sum of lines 22 and 28)	0	29. 00		
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	0	29. 01		
27.01	Di sproporti onate Share Adjustment	0	27.01		
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	3. 70	30. 00		
31. 00	Percentage of Medicaid patient days (see instructions)	21. 63			
32. 00	Sum of lines 30 and 31			25. 33	
33. 00	Allowable disproportionate share percentage (see instructions)	)		10. 11	
	Di sproporti onate share adjustment (see instructions)			86, 905	
			·		

Heal th	Financial Systems DEKALB MEMORIAL	. HOSPI TAL	In Lie	eu of Form CMS-2	2552-10			
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A	pared:			
		Title XVIII	Hospi tal Pri or to 10/1 1.00	PPS 0n/After 10/1 2.00				
35. 00 35. 01 35. 02	Uncompensated Care Adjustment Total uncompensated care amount (see instructions) Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, ento (see instructions)	er zero on this line)	0. 000000000		35. 01			
35. 03 36. 00	35.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 36.00 Total uncompensated care (sum of columns 1 and 2 on line 35.03) 283,3							
40. 00	Additional payment for high percentage of ESRD beneficiary dis Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)		0		40. 00			
			Before 1/1	On/After 1/1				
	T		1. 00	1. 01				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 66 instructions) Total ESRD Medicare covered and paid discharges excluding MS-lan 685. (see instructions)	•	0		41. 00			
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qualitated Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions)		0.00	l I	42. 00 43. 00			
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44. 00			
45. 00 46. 00	Average weekly cost for dialysis treatments (see instructions Total additional payment (line 45 times line 44 times line 41		0.00	0.00	46. 00			
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, solonly. (see instructions)	small rural hospitals	3, 811, 842 0		47. 00 48. 00			
	only. (See This tradet only)			Amount				
10.00				1.00	10.00			
49. 00 50. 00 51. 00 52. 00 53. 00 54. 00 54. 01	Total payment for inpatient operating costs (see instructions Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, III Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment	nd Pt. II, as applicable) III, see instructions) ne 49 see instructions).		3, 811, 842 272, 115 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01			
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intri-Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments	ructions) II, column 9, lines 30 t	hrough 35).	0 0 0 0 4, 083, 957 5, 884	59. 00			
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)		4, 078, 073 583, 296 20, 881 29, 920 19, 448 19, 901	62. 00 63. 00 64. 00				
67. 00 68. 00 69. 00 70. 00 70. 50 70. 88	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment	3, 493, 344 0 0 0 0 0	67. 00 68. 00 69. 00 70. 00 70. 50 70. 88					
70. 89 70. 90 70. 91 70. 92 70. 93	Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ructions)		0 0 0 0 0 1, 707	70. 89 70. 90 70. 91 70. 92			
70. 94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation			-6, 189				

Hoal +b	Financial Systems DEKALB MEMORIAL	UOSDI TAI		In Lio	u of Form CMS-2	2552 10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider Co	CN: 15-0045	Peri od: From 10/01/2015 To 09/30/2016	Worksheet E Part A	pared:
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			2016	503, 201	70. 97
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			3, 992, 063	71. 00
71. 01	Sequestration adjustment (see instructions)				79, 841	71. 01
72.00	Interim payments				3, 964, 105	72. 00
73.00	Tentative settlement (for contractor use only)				0	73. 00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72	, and 73)			-51, 883	74.00
75. 00	1	nce with			150, 304	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
00 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	trusti ana)			0	90.00
90. 00 91. 00	, ,	tructions)			0	
91.00	Operating outlier reconciliation adjustment amount (see instr	wati ana)			0	91.00
92.00					0	92.00
	The rate used to calculate the time value of money (see instruc				0.00	
95.00	,				0.00	95.00
96. 00					0	
90.00	Trille value of money for capital related expenses (see fristruc	11 0115)		Prior to 10/1		70.00
				1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	
100.00	HSP bonus amount (see instructions)				0	100.00
100.00	HVBP Adjustment for HSP Bonus Payment					100.00
101 00	HVBP adjustment factor (see instructions)				1. 0013070501	101 00
	HVBP adjustment amount for HSP bonus payment (see instruction	ıs)				102.00
. 52. 00	HRR Adjustment for HSP Bonus Payment					1.52.00
103.00	HRR adjustment factor (see instructions)				0,0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions	;)				104. 00
	, , , , , , , , , , , , , , , , , , ,	•		ı		

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 10/01/2015 Part A Exhibit 4
To 09/30/2016 Date/Time Prepared: 2/23/2017 4:56 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0045

					'	0 077 307 2010	2/23/2017 4:5	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	On/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1. 00	1.00	2.00	3.00		0.00	1. 00
00	payments	00	١	ŭ				
1. 01	DRG amounts other than outlier payments for discharges	1. 01	0	0	С		0	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	3, 438, 370	O		3, 438, 370	3, 438, 370	1. 02
1. 03	occurring on or after October 1 DRG for Federal specific	1. 03	0	0	r		0	1. 03
1.03	operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	C		U	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for	2. 00	3, 172	0	C	3, 172	3, 172	2. 00
2. 01	discharges (see instructions) Outlier payments for	2. 02	0	0	0	0	0	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation  Managed care simulated	3. 00	0	0	C	0	0	4. 00
	payments							
5. 00	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
3.00	A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.00000		3.00
6.00	IME payment adjustment (see instructions)	22. 00	0	0	C	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	С	0	0	6. 01
	instructions)							
7.00	Indirect Medical Education Adju					0.000000		7 00
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	C	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	O	O	C	O	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	С	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	O	С	О	0	9. 01
	Di sproporti onate Share Adjustme	ent						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1011	0. 1011	0. 1011	0. 1011		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34. 00	86, 905	0	С	86, 905	86, 905	11. 00
11. 01	Uncompensated care payments	36. 00	283, 395	0	C	283, 395	283, 395	11. 01
	Additional payment for high per	centage of ESF		di scharges				
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	С	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	3, 811, 842 0	0	C	3, 811, 842 0	3, 811, 842 0	13. 00 14. 00
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)							
15. 00	Total payment for inpatient operating costs (see	49. 00	3, 811, 842	0	C	3, 811, 842	3, 811, 842	15. 00
16. 00	instructions) Payment for inpatient program capital	50. 00	272, 115	0	C	272, 115	272, 115	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	С	О	0	17. 00
17. 01	Net organ aquisition cost	55. 00	О	О	О	o	0	
17. 02	Credits received from manufacturers for replaced	68. 00	0	0	C	0	0	17. 02
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	C	0	0	18. 00
	HISTI UCTI UHS)		l l			<u> </u>		l .

						o 09/30/2016		pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3.00	4. 00	5. 00	
19. 00	SUBTOTAL			0	(	4, 083, 957	4, 083, 957	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	271, 045	0	(	271, 045	271, 045	20. 00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	(	0	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	1, 070	0	(	1, 070	1, 070	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	(	0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0.0000	0. 0000		22. 00
	percentage (see instructions)							
23. 00		6. 00	0	0	(	0	0	23. 00
	adjustment (see instructions)							
24. 00	Allowable disproportionate	10. 00	0. 0000	0.0000	0.0000	0.0000		24. 00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11. 00	0	0	C	0	0	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	272, 115	0	C	272, 115	272, 115	26. 00
	payments (see instructions)							
			(Amounts to E,					
		line	Part A)	0.00	0.00	4.00	F 00	
07.00	T	0	1. 00	2. 00	3.00	4. 00	5. 00	07.00
27. 00	Low volume adjustment factor				0. 000000	0. 123214	_	27. 00
28. 00	Low volume adjustment	70. 96				)	0	28. 00
	(transfer amount to Wkst. E,							
00.00	Pt. A, line)	70.07				F00 004	E00 004	00.00
29. 00	Low volume adjustment	70. 97				503, 201	503, 201	29.00
	(transfer amount to Wkst. E,							
100.00	Pt. A, line)							100 00
100.00	Transfer low volume		Y					100. 00
	adjustments to Wkst. E, Pt. A.	l			l	[		I

HU3P1 1	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	IION EXHIBIT 5		Fi		Date/Time Pre 2/23/2017 4:5	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2. 00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	0	0		0	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	3, 438, 370		3, 438, 370	3, 438, 370	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	O	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	O		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	3, 172	0	3, 172	3, 172	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	O	0	0	0	
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	0	0	0	3. 00 4. 00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000			5. 00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0	0	0	0	6. 00 6. 01
	instructions) Indirect Medical Education Adjustment for the	Add-on for Se	ction 122 of the	he MMA			
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	o	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	o	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	9. 01
10 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33. 00	0. 1011	0. 1011	0. 1011		10. 00
10.00	(see instructions)	33.00	0. 1011	0. 1011	0. 1011		10.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	86, 905	0	86, 905	86, 905	11. 00
11. 01	Uncompensated care payments	36.00	283, 395	0	0	0	11. 01
	Additional payment for high percentage of ESF	D beneficiary	di scharges				
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47. 00 48. 00	3, 811, 842 0	0	3, 811, 842 0	3, 811, 842 0	13. 00 14. 00
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	3, 811, 842	0	3, 811, 842	3, 811, 842	15. 00
16.00	Payment for inpatient program capital	50.00	272, 115	0	272, 115	272, 115	
17.00	Special add-on payments for new technologies	54.00		0	0	0	17.00
17. 01 17. 02	Credits received from manufacturers for	55. 00 68. 00	0	0	0	0	17. 01 17. 02
18. 00	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
19. 00	SUBTOTAL			0	4, 083, 957	4, 083, 957	19. 00

Heal th	Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		F	reriod: rom 10/01/2015 o 09/30/2016	Worksheet E Part A Exhibi Date/Time Pre 2/23/2017 4:5	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	271, 045	0	271, 045	271, 045	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
21. 00	Capital DRG outlier payments	2.00	1, 070	0	1, 070	1, 070	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.0000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	272, 115	0	272, 115	272, 115	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1, 00	2, 00	3. 00	4. 00	
27. 00		0	1.00	2.00	3.00	4.00	27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	0	1	0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	503, 201	ď	503, 201	503, 201	29. 00
30. 00	HVBP payment adjustment (see instructions)	70. 93	1, 707	0	1	1, 707	30.00
30. 00	HVBP payment adjustment for HSP bonus	70. 90	1, 707		1, 707	1,707	30. 00
30. 01	payment (see instructions)						
31.00	HRR adjustment (see instructions)	70. 94	-6, 189	0	-6, 189	-6, 189	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	0	0	0	31. 01

0

70. 99

100.00

0 32. 00

(Amt. to Wkst. E, Pt. A) 4.00

3.00

2.00

1.00

Ν

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	DEKALB MEMORIAL HO	OSPI TAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	P	Provider CCN:		From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/23/2017 4:56 pm
		T' 11 \A	/		DDC

			10 09/30/2010	2/23/2017 4:5	
		Title XVIII	Hospi tal	PPS	o piii
		TI CI O XVIII	nospi tui	110	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			13, 265	1.00
2. 00	Medical and other services (see Fristructions)  Medical and other services reimbursed under OPPS (see instruct	tions)		3, 894, 199	
	· · · · · · · · · · · · · · · · · · ·	ti ons)			
3.00	PPS payments			3, 054, 104	
4.00	Outlier payment (see instructions)			8, 268	
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV col 13 line 200		0	
10. 00	Organ acqui si ti ons	14, 661. 10, 11116 200		0	
11. 00				-	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			13, 265	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12. 00	Ancillary service charges			22, 674	
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)			22, 674	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for p	payment for services on a	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e			_	
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	3)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			22, 674	
		lv if line 10 svessde lin	20 11) (000		
19. 00	Excess of customary charges over reasonable cost (complete onl	y ii iine is exceeds iii	ie II) (See	9, 409	19. 00
	instructions)		40) (		
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds lir	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		13, 265	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			3, 062, 372	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH see instructions)		685, 536	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p		and 221 (coo	2, 390, 101	
27.00	instructions)	or us the sum of fittes 22	and 23] (See	2, 370, 101	27.00
20.00		no FO)		0	20.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30. 00	Subtotal (sum of lines 27 through 29)			2, 390, 101	
31. 00	Primary payer payments			69	
32.00	Subtotal (line 30 minus line 31)			2, 390, 032	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			126, 218	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			82, 042	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		119, 242	
37. 00	Subtotal (see instructions)	detrons)		2, 472, 074	
	· · · · · · · · · · · · · · · · · · ·			2, 472, 074	
38. 00	MSP-LCC reconciliation amount from PS&R				
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions			0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruct	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			2, 472, 074	40. 00
40. 01	Sequestration adjustment (see instructions)	49, 441	40. 01		
41.00	Interim payments	2, 335, 210	1		
42. 00	· ·				42.00
43. 00	•				43. 00
	, , , ,				
44. 00					44. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93. 00
	Total (sum of lines 91 and 93)			0	94.00
			'		

Health Financial Systems DEK.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 10/01/2015 Part I
To 09/30/2016 Date/Time Prepared: 2/23/2017 4:56 pm Provider CCN: 15-0045

					2/23/2017 4:56	5 pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4.00	
1.00	Total interim payments paid to provider		3, 964, 105		2, 335, 210	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		o	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3.54	Cultitatal (aum af linna 2 01 2 40 minus aum af linna		0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 964, 105		2, 335, 210	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		3, 704, 103		2, 333, 210	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			L		
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			I		
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravi dan ta Dragnam		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 51	TENTATI VE TO PROGRAM					5. 50
5. 51						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
0. , ,	5. 50-5. 98)		Ĭ			0. ,,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		87, 423	6. 01
6.02	SETTLEMENT TO PROGRAM		51, 883		0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 912, 222		2, 422, 633	7. 00
				Contractor	NPR Date	
		,	`	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	(	J	1. 00	2. 00	8. 00
0.00	Ivalie of Contractor			l	ı l	0.00

Heal th	Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of					
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0045	Peri od: From 10/01/2015 To 09/30/2016			
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	V				
1.00	.00   Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2   1,523					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		6, 462	4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			142, 842, 786	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20		904, 000	6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00	
9.00	Sequestration adjustment amount (see instructions)			ol	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		0	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)	·		0	30.00	
31.00	Other Adjustment (specify)			ol	31.00	
22 00	On Polance due provider (line 0 (or line 10) minus line 30 and line 31) (occ instructions)					

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

0 30.00 0 31.00 0 32.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0045	Peri od: From 10/01/2015 Part VII To 09/30/2016 Date/Time Prepared: 2/23/2017 4:56 pm

			lo 09/30/2016	Date/lime Pre 2/23/2017 4:5	
		Title XIX	Hospi tal	Cost	Орш
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		460, 566		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		460, 566	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		460, 566	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		776, 290		8. 00
9.00	Ancillary service charges		679, 951	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 456, 241	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis				
14.00	Amounts that would have been realized from patients liable for		0	0	14. 00
	a charge basis had such payment been made in accordance with 4	12 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	1
16. 00	Total customary charges (see instructions)		1, 456, 241	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	995, 675	0	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)			0	10.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr		٩	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		460, 566	0	21.00
22. 00	Other than outlier payments	Compreted for PPS provide	0	0	22. 00
	Outlier payments		0	0	
24. 00	Program capital payments		0	U	24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		460, 566	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1007 000		27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	, ,	ı	460, 566	0	
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	460, 566	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•	0	0	37. 00
38.00	Subtotal (line 36 ± line 37)		460, 566	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		o		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		460, 566	0	40. 00
41.00	Interim payments		585, 273	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)		-124, 707	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

Health Financial Systems

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0045 P

OH y)					2/23/2017 4:5	6 pm
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1, 049, 131		0	_	
2. 00 3. 00	Temporary investments Notes receivable	0	0	0	0	2. 00 3. 00
4.00	Accounts recei vable	8, 040, 649	1	0	0	
5. 00	Other recei vable	0,040,047		0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	0	Ö	0	Ō	6. 00
7.00	Inventory	1, 267, 616	0	0	0	
8.00	Prepai d expenses	610, 417		0	0	
9.00	Other current assets	85, 646		0	0	1
10.00	Due from other funds	11 052 450	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	11, 053, 459	) 0	0		11. 00
12. 00	Land	393, 118	0	0	0	12. 00
13. 00	Land improvements	1, 830, 710		0	1	13. 00
14.00	Accumul ated depreciation	-1, 493, 612		0	0	14. 00
15.00	Bui I di ngs	61, 067, 184	0	0	0	15. 00
16. 00	Accumulated depreciation	-29, 938, 340	1	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumulated depreciation	-67, 788	1	0	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation	-248, 828	0	0	0	19. 00 20. 00
21. 00	Automobiles and trucks	-240, 020		0	0	20.00
22. 00	Accumulated depreciation			0	0	22. 00
23. 00	Major movable equipment	24, 241, 233	1	0	Ö	23. 00
24. 00	Accumulated depreciation	-16, 694, 886	1	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	-397, 333	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable	20 401 450	0	0	0	29. 00 30. 00
30.00	Total fixed assets (sum of lines 12-29)  OTHER ASSETS	38, 691, 458	0	0		30.00
31. 00	Investments	15, 957, 764	. 0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	68, 074		0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	16, 025, 838		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	65, 770, 755	0	0	0	36. 00
37. 00	Accounts payable	2, 338, 780	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	2, 712, 938	1	0	· -	38.00
39. 00	Payroll taxes payable	0	o	0	0	39. 00
40.00	Notes and Loans payable (short term)	1, 122, 785	0	0	0	40. 00
41. 00	Deferred income	0	0	0	0	41. 00
42. 00	Accel erated payments	0	)	_	_	42. 00
43.00	Due to other funds	1 221 (00	0	0	0	43. 00
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	1, 221, 698 7, 396, 201		0	0 0	1
43.00	LONG TERM LIABILITIES	7, 390, 201		0		45.00
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	9, 090, 827	0	0		
48.00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	680, 509		0	-	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9, 771, 336			-	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	17, 167, 537	'] 0	0	0	51.00
52. 00	CAPITAL ACCOUNTS  General fund balance	48, 603, 218	1		I	52.00
53. 00	Specific purpose fund	40,003,210	ĺ o			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted		1	0		55. 00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant		1		0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,		1		0	58. 00
EO 00	replacement, and expansion	40 400 010	,	_	_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	48, 603, 218 65, 770, 755		0	0	
00.00	[59]	05, 770, 755		0		55. 55
	1 - 1	1	1	ı	1	1

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 15-0045

Peri od: Worksheet G-1 From 10/01/2015

09/30/2016 Date/Time Prepared: 2/23/2017 4:56 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 47, 294, 299 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 1, 308, 919 2.00 3.00 Total (sum of line 1 and line 2) 48, 603, 218 0 3.00 4.00 0 Additions (credit adjustments) (specify) 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 48, 603, 218 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 48, 603, 218 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 19.00 Fund balance at end of period per balance 19.00 Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0045

			To 09/30/2016	Date/Time Pre 2/23/2017 4:5	
	Cost Center Description	Inpatient	Outpati ent	Total	J DIII
		1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	11, 797, 14	16	11, 797, 146	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE	44 707 4		44 707 444	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)	11, 797, 14	16	11, 797, 146	10. 00
	Intensive Care Type Inpatient Hospital Services	1			
11.00	INTENSIVE CARE UNIT	4, 697, 42	21	4, 697, 421	
12.00	CORONARY CARE UNIT				12.00
13. 00 14. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT				13. 00 14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	4, 697, 42	01	4, 697, 421	
10.00	11-15)	4, 097, 42	1	4, 097, 421	16.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	16, 494, 56	.7	16, 494, 567	17. 00
18. 00	Ancillary services	23, 494, 78			
19. 00	Outpatient services	2, 430, 45			19.00
20. 00	RURAL HEALTH CLINIC	2, 100, 10	0 10, 100, 210	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	l .	21.00
22. 00	HOME HEALTH AGENCY		1, 167, 558	<b>l</b>	22. 00
23. 00	AMBULANCE SERVICES		0 5, 684, 137	5, 684, 137	23. 00
24. 00	CMHC			.,	24. 00
24. 10	CORF		0 0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26.00	HOSPI CE	42, 16	582, 734	624, 902	26. 00
27.00	DI ETARY		0 22, 915	22, 915	27. 00
27. 01	DHMG PHYSICIANS		0 13, 579, 564	13, 579, 564	27. 01
27. 02	SELF-I NSURANCE	334, 19	1, 259, 173	1, 593, 370	27. 02
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	42, 796, 17	75 115, 242, 462	158, 038, 637	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		66, 218, 140		29. 00
30. 00	ADD (SPECIFY)		0		30.00
31. 00			0		31.00
32. 00			0		32.00
33.00			0		33. 00
34.00			0		34.00
35. 00	T-+-1		0		35.00
36. 00 37. 00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)		0		36. 00 37. 00
38. 00	DEDUCT (SPECIFY)		0		38.00
39. 00			0		39.00
40. 00			0		40.00
41. 00			0		41.00
42. 00	Total deductions (sum of lines 37-41)				42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er	66, 218, 140		43.00
10. 00	to Wkst. G-3, line 4)	·	00, 210, 140		10.00
		•	"	•	•

	EL LA CALLE MENON A			6.5. 0110.0		
	Financial Systems DEKALB MEMORIA MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0045	Period:	u of Form CMS-2 Worksheet G-3	2552-10	
SIAIL	IENT OF REVENUES AND EXPENSES	FI OVI del CCN. 15-0045	From 10/01/2015	WOLKSHEET G-3		
	To 09/30/2016 D					
				2/23/2017 4: 5	5 pm	
				1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		158, 038, 637	1. 00	
2. 00	Less contractual allowances and discounts on patients' accou			99, 241, 579	2. 00	
3.00	Net patient revenues (line 1 minus line 2)			58, 797, 058	3. 00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	2 43)		66, 218, 140		
5.00	Net income from service to patients (line 3 minus line 4)	•		-7, 421, 082	5.00	
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00	Income from investments			0	7. 00	
8.00	00 Revenues from telephone and other miscellaneous communication services					
9.00	Revenue from television and radio service			0		
10.00	Purchase di scounts			0		
11. 00	Rebates and refunds of expenses			0	11. 00	
12. 00	Parking lot receipts			0	12.00	
13. 00	Revenue from Laundry and Linen service			0	13.00	
14. 00	Revenue from meals sold to employees and guests			0	14. 00	
15. 00	Revenue from rental of living quarters			0		
16. 00	Revenue from sale of medical and surgical supplies to other	than patients		0		
17. 00	Revenue from sale of drugs to other than patients				17. 00	
18. 00	Revenue from sale of medical records and abstracts				18. 00	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			-	19. 00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
21. 00	Rental of vending machines			0	21. 00	
22. 00	Rental of hospital space			0	22. 00	
23. 00	Governmental appropriations			0	23. 00	
24. 00	MI SCELLANEOUS I NCOME			6, 944, 788		
24. 01	OTHER NON-OPERATING INCOME			1, 785, 214		
25. 00	Total other income (sum of lines 6-24)			8, 730, 002		
26. 00	Total (line 5 plus line 25) ROUNDING			1, 308, 920 1	26. 00 27. 00	
27. 00 28. 00	Total other expenses (sum of line 27 and subscripts)			1	27. 00 28. 00	
	Net income (or loss) for the period (line 26 minus line 28)			1, 308, 919		
27.00	I her theome (or 1055) for the period (title 20 millius title 20)		I	1, 300, 919	∠7. UU	

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

0

0

0

5, 275

0

0

0

0

1, 156, 158

Ω

0

0

0

O

0

1. 148. 014

20.00

21.00

22.00

23.00

23.50

24.00

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

24.00 Total (sum of lines 1-23)

Home Delivered Meals Program

20.00

21.00

22.00

23.00

23. 50

Heal th	Financial Systems		DEKALB MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST		Provi der C	CN: 15-0045	Peri od: From 10/01/2015	Worksheet H-1 Part I	
				HHA CCN:	15-7157	To 09/30/2016	Date/Time Pre	pared:
						Home Health	2/23/2017 4: 5 PPS	ь рш
			C: +-1 D-1-		1	Agency I		
			Capital Rela	itea Costs				
		Net Expenses	Bl dgs &	Movabl e	Plant	Transportati on	Subtotal	
		for Cost Allocation	Fi xtures	Equi pment	Operation 8 Maintenance		(cols. 0-4)	
		(from Wkst. H,						
		col . 10) 0	1.00	2. 00	3.00	4. 00	4A. 00	
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures	0	0				0	1. 00
2.00	Capital Related - Movable	0		0			0	2. 00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3. 00
4.00	Transportation	Ö	Ö	Ö		0 0	0	4. 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	559, 386	0	0		0 0	559, 386	5. 00
6. 00	Skilled Nursing Care	305, 865	0	0		0 0	305, 865	6. 00
7.00	Physical Therapy	98, 969	0	0	l .	0 0	98, 969	1
8. 00 9. 00	Occupational Therapy Speech Pathology	39, 837 889	0	0		0 0	39, 837 889	1
10.00	Medical Social Services	15, 835	O	0		0 0	15, 835	10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	127, 233	0	0		0 0	127, 233 0	1
13. 00	Drugs	0	0	0		0	0	1
14. 00	DME	0	0	0		0 0	0	14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16. 00	Respiratory Therapy	0	0	0		0 0	0	16. 00
17. 00 18. 00	Private Duty Nursing Clinic	0	0	0		0 0	0	
19. 00	Health Promotion Activities	Ö	Ö	Ö		0 0	0	1
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0		0 0	0	
22. 00	Homemaker Service	0	0	0		0 0	0	1
23. 00	All Others (specify)	0	0	0		0 0	0	
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)	1, 148, 014	0	0	1	0 0	0 1, 148, 014	
		Admi ni strati ve						
		& General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS	0.00	0.00					
1. 00	Capital Related - Bldg. & Fixtures							1. 00
2.00	Capital Related - Movable							2. 00
3. 00	Equipment Plant Operation & Maintenance							3. 00
4.00	Transportation							4. 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	559, 386						5. 00
6.00	Skilled Nursing Care	290, 671	596, 536					6. 00
7.00	Physical Therapy	94, 052	193, 021					7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	37, 858 845	77, 695 1, 734					8. 00 9. 00
10.00	Medical Social Services	15, 048	30, 883					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	120, 912	248, 145 0					11. 00 12. 00
13. 00	Drugs	0	О					13. 00
14. 00	HHA NONREI MBURSABLE SERVI CES	0	0					14. 00
15. 00	Home Dialysis Aide Services	0	0					15. 00
16. 00 17. 00	Respiratory Therapy	0	0					16. 00 17. 00
18. 00	Private Duty Nursing Clinic		0					18.00
19.00	1	0	0					19. 00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0 0	0					20.00
22. 00	Homemaker Service	o o	О					22. 00
23. 00 23. 50	1 3/	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		1, 148, 014					24. 00

	Financial Systems LLOCATION - HHA STATISTICAL BAS	IS	DEKALB MEMORI	Provider C	CN: 15-0045	Peri od:	u of Form CMS-2 Worksheet H-1	2002-10
				HHA CCN:		From 10/01/2015	Part II Date/Time Prep 2/23/2017 4:50	pared: 6 pm
						Home Health	PPS	<u> </u>
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportatio	nReconciliation	Admi ni strati ve	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
		1.00	0.00	(SQUARE FEET)		54.00		
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5A. 00	5. 00	
1. 00	Capital Related - Bldg. &	0				0		1. 00
1.00	Fixtures	0						1.00
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0	)	0		3. 00
4.00	Transportation (see	0	0	0	)	0		4. 00
	instructions)							
5.00	Administrative and General	0	0	0		0 -559, 386	588, 628	5. 00
	HHA REIMBURSABLE SERVICES	_			1		225 245	,
6.00	Skilled Nursing Care	0	0	0	1	0 0	305, 865	6. 00
7. 00 8. 00	Physical Therapy Occupational Therapy	0	0	0	1	0 0	98, 969	7. 00 8. 00
9.00	Speech Pathology	0	0	0		0 0	39, 837 889	
10.00	Medical Social Services	0	0	0	1	0	15, 835	
11. 00	Home Health Aide	0	0	0			127, 233	
12.00	Supplies (see instructions)	0	0	0		0 0	127, 233	12.00
13. 00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0		0 0	0	14. 00
	HHA NONREIMBURSABLE SERVICES				•			
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16.00	Respiratory Therapy	0	0	0	1	0	0	16. 00
17. 00	Private Duty Nursing	0	0	0	l .	0	0	17. 00
18. 00	Clinic	0	0	0	1	0	0	18. 00
19.00	Health Promotion Activities	0	0	0	1	0 0	0	
20.00	Day Care Program	0	0	0	1	0 0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0	1	0 0	0	21. 00
22. 00 23. 00	Homemaker Service	0	0	0	1	0 0	0	22. 00 23. 00
23. 00	All Others (specify) Telemedicine		0	0		0 0	0	23. 00
24. 00	Total (sum of lines 1-23)	0	0	0		0 -559, 386	588, 628	
25. 00	Cost To Be Allocated (per	) n	0	0		0 -337, 380	559, 386	
20.00	Worksheet H-1, Part I)		0				337, 300	25.00
	Unit Cost Multiplier		0. 000000	0. 000000	0. 00000	1		26. 00

						Home Health Agency I	PPS	о ріп
			CAPITAL RELATED COSTS					
	Cost Center Description	HHA Trial		MAC WEST - N		- GARRETT CLINIC	BUTLER - NEW	
		Bal ance (1)	1. 00	1. 01	NEW 1. 02	- NEW 1.03	1. 04	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	0 596, 536 193, 021 77, 695 1, 734 30, 883 248, 145 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	1.01	0 2, 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	595 0 0 0 0 0 0 0 0 0 0 0 0 0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
			CAP	TAL RELATED	COSTS			
	Cost Center Description	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS NEW	DAY SPRING NEW	- MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
1.00	Administration and Course	1.05	1.06	1. 07	1.08	2.00	4. 00	1 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.00

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

						Home Health	PPS	
	Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	Agency I HOUSEKEEPING	DI ETARY	
	cost conton beschiption	oub to tu.	& GENERAL	PLANT	LINEN SERVICE	HOODENEEL THO	51217	
		4A	5. 00	7. 00	8. 00	9. 00	10. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Heal th Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	21, 035 596, 536 193, 021 77, 695 1, 734 30, 883 248, 145 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 766 106, 798 34, 556 13, 910 310 5, 529 44, 425 0 0 0 0 0 0 0 0 0 0 209, 294	87, 766 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28, 079 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.  Cost Center Description	SNACK BAR	CAFETERI A	NURSING ADMINISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		10. 01	11. 00	13.00	14. 00	15. 00	16. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27, 475 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Peri od: Worksheet H-2
From 10/01/2015
To 09/30/2016 Part I
Date/Time Prepared: 2/23/2017 4:56 pm
Home Health PPS Provider CCN: 15-0045 HHA CCN: 15-7157

						Home Health	PPS	
						Agency I		
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
				Residents Cost		A&G (see Part	Costs	
				& Post		11)		
				Stepdown				
		47.00	04.00	Adjustments	0/ 00	07.00	00.00	
4 00		17. 00	24. 00	25. 00	26.00	27. 00	28. 00	4 00
1.00	Administrative and General	0	291, 205		291, 205		054 (54	1.00
2.00	Skilled Nursing Care	0	703, 334		703, 334		854, 651	2. 00
3.00	Physi cal Therapy	0	227, 577		227, 577	1	276, 539	
4.00	Occupational Therapy	0	91, 605		91, 605		111, 313	•
5.00	Speech Pathology	0	2, 044		2, 044		2, 484	
6.00	Medical Social Services	0	36, 412		36, 412		44, 246	
7.00	Home Health Aide	0	292, 570	0	292, 570	62, 944	355, 514	
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9.00	Drugs	0	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	0	12. 00
13.00	Private Duty Nursing	0	0	0	0	0	0	13. 00
14.00	Clinic	0	0	0	0	0	0	14. 00
15.00	Health Promotion Activities	0	0	0	0	0	0	15. 00
16.00	Day Care Program	0	0	0	0	0	0	16. 00
17.00	Home Delivered Meals Program	0	0	0	0	o	0	17. 00
18.00	Homemaker Service	0	0	0	0	o	0	18. 00
19.00	All Others (specify)	0	0	0	0	o	0	19. 00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20.00	Total (sum of lines 1-19) (2)	0	1, 644, 747	0	1, 644, 747	291, 205	1, 644, 747	20.00
21.00	Unit Cost Multiplier: column					0. 215143		21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	· ·			•	•			

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS	) HHA COST CENTERS STATISTICAL	Provi der CCN: 15-0045 HHA CCN: 15-7157	Peri od: From 10/01/2015 To 09/30/2016	Worksheet H-2 Part II Date/Time Prepared: 2/23/2017 4:56 pm
			Homo Hoal th	DDC

						Home Health Agency I	PPS	
		CAPI TAL				Agency 1		
	Cost Center Description	RELATED COSTS BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX -	GARRETT CLINIC	BUTLER - NEW	MAC EAST - NEW	
		(SQUARE FEET)	(SOUADE EEET)	NEW	- NEW (SQUARE FEET)	(SQUARE FEET)	(SOUADE EEET)	
		1.00	(SQUARE FEET) 1.01	(SQUARE FEET) 1.02	1. 03	1. 04	(SQUARE FEET) 1.05	
1.00	Administrative and General	0	0	_,		0	0	1. 00
2. 00 3. 00	Skilled Nursing Care Physical Therapy	0	0	0		0	0 0	2. 00 3. 00
4. 00	Occupational Therapy	0	0	0	ő	0	o	4. 00
5. 00 6. 00	Speech Pathology Medical Social Services	0	0	0		0	0	5. 00
7.00	Home Health Aide		0	0	0	0		6. 00 7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	O	8. 00
9. 00 10. 00	Drugs DME	0	0	0	0	0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services		0	0		0	o o	11. 00
12. 00	Respiratory Therapy	0	0	0		0	o	12. 00
13. 00 14. 00	Private Duty Nursing	0	0	0		0	[ 0   0	13. 00 14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	o o	15. 00
16. 00	Day Care Program	0	0	0	0	0	0	16. 00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0	0	0	0	0	17. 00 18. 00
19. 00	All Others (specify)	0	0	Ö	ő	0	o o	19. 00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20. 00 21. 00	Total (sum of lines 1-19) Total cost to be allocated	0	0	2, 772 2, 595		0	0	20. 00 21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000			0. 000000	0. 000000	
			CAPITAL REL	_ATED COSTS				
	Cost Center Description	GARRETT LAB -		DAY SPRING -	MVBLE EQUIP	EMPLOYEE	Reconciliation	
		NEW (SQUARE FEET)	NEW (SQUARE FEET)	NEW (SQUARE FEET)	(SQUARE FEET)	BENEFITS DEPARTMENT		
		(SQUARE FEET)	(SQUARE TEET)	(SQUARE TEET)		(UNADJUSTED		
		1.06	1. 07	1. 08	2.00	SALARY) 4. 00	5A	
1. 00	Administrative and General	0	0	1.08		744, 256	0	1. 00
2.00	Skilled Nursing Care	0	0	0	_	0	0	2.00
3. 00 4. 00	Physical Therapy Occupational Therapy	0	0	0	0	0	0	3. 00 4. 00
5. 00	Speech Pathology	Ö	0	Ö	ő	0	Ö	5. 00
6.00	Medical Social Services	0	0	0	0	0	0	6. 00
7. 00 8. 00	Home Health Aide Supplies (see instructions)	0	0	0	0	0	0	7. 00 8. 00
9. 00	Drugs	Ö	0	Ö	ő	0	Ö	9. 00
10.00	DME	0	0	0	0	0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0	0	0	0	11. 00 12. 00
13. 00	Private Duty Nursing	0	0	0	0	0	O	13. 00
14.00	Clinic	0	0	0	0	0	0	
15. 00 16. 00	Health Promotion Activities Day Care Program		0	0		0	[ 0   0	15. 00 16. 00
17. 00	Home Delivered Meals Program	0	0	0		0	O	17. 00
18. 00 19. 00	Homemaker Service All Others (specify)	0	0	0		0	0	18. 00 19. 00
19. 00	Telemedicine		0	0		0	0	19. 00
20.00	Total (sum of lines 1-19)	0	0	0	0	744, 256		20.00
21.00	Total cost to be allocated Unit cost multiplier	0. 000000	0. 000000	0. 000000	0. 000000	18, 440 0. 024776		21. 00 22. 00
00	1	3. 000000	3. 000000			3.021770	1	00

							2/23/201/ 4:50	o piii
						Home Health	PPS	
						Agency I		
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	SNACK BAR	
		& GENERAL	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED)	
		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF				
		,	,	LAUNDRY)				
		5. 00	7. 00	8. 00	9. 00	10.00	10. 01	
1. 00	Administrative and General	21, 035	2,772	0			0	1. 00
2. 00	Skilled Nursing Care	596, 536	2, 7,2	Ö				2. 00
3. 00	Physical Therapy	193, 021	Ö	0			1	3. 00
4. 00			0				0	
	Occupational Therapy	77, 695	_	1			1	4. 00
5.00	Speech Pathology	1, 734	0	0			0	5. 00
6. 00	Medical Social Services	30, 883	0	0			0	6. 00
7.00	Home Health Aide	248, 145	0	0			0	7. 00
8.00	Supplies (see instructions)	0	0	0	C	0	0	8. 00
9.00	Drugs	0	0	0	C	0	0	9.00
10.00	DME	0	0	0	C	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	l o		0	0	11.00
12. 00	Respiratory Therapy	0	0	0		0	0	12.00
13. 00	Private Duty Nursing	0	0	Ö			o o	13. 00
14. 00	Clinic	0	0	ĺ			o o	14. 00
15. 00	Health Promotion Activities		0	0	o c		0	15. 00
16. 00			0	0			0	16. 00
	Day Care Program	0	0	0			l "	
17. 00	Home Delivered Meals Program	0	0	0	C		0	17. 00
18. 00	Homemaker Service	0	0	0	C		0	18. 00
19. 00	All Others (specify)	0	0	0	C	_	0	19.00
19. 50	Tel emedi ci ne	0	0	0	C	0	0	19. 50
20.00	Total (sum of lines 1-19)	1, 169, 049	2, 772	0	2, 772	0	0	20.00
21.00	Total cost to be allocated	209, 294	87, 766	0	28, 079	0	0	21.00
22.00	Unit cost multiplier	0. 179029	31. 661616	0. 000000	10. 129509	0.000000	0. 000000	22.00
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		CALLILIA	DNITCHON	CLIVITAL	FIIANWACI	WEDICAL	SUCTAL SERVICE	
			ADMI NI STRATI ON		(COSTED	RECORDS &	SUCIAL SERVICE	
				SERVICES &	(COSTED	RECORDS &		
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	(TIME SPENT)	
			ADMINISTRATION  (DIRECT NRS	SERVICES & SUPPLY (COSTED	(COSTED	RECORDS & LI BRARY (GROSS REVE		
			ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED	RECORDS & LI BRARY	(TIME SPENT)	
1.00	·	(FTES)	ADMI NI STRATI ON  (DI RECT NRS  I NG)  13.00	SERVICES & SUPPLY (COSTED REQUIS.) 14.00	(COSTED REQUIS.)	RECORDS & LI BRARY (GROSS REVE NUE) 16.00	(TIME SPENT)	1, 00
1.00	Administrative and General	(FTES) 11. 00 1, 374	ADMI NI STRATI ON  (DI RECT NRS I NG) 13.00 28,237	SERVI CES & SUPPLY (COSTED REQUI S. )	(COSTED REQUIS.)	RECORDS & LI BRARY (GROSS REVE NUE) 16.00	(TIME SPENT)  17.00 0	1.00
2.00	Administrative and General Skilled Nursing Care	(FTES)  11. 00  1, 374  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0	SERVI CES & SUPPLY (COSTED REQUI S.)  14.00	(COSTED REQUIS.)	RECORDS & LI BRARY (GROSS REVE NUE) 16. 00 0	(TIME SPENT)  17.00  0	2. 00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	(FTES) 11. 00 1, 374 0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0	SERVI CES & SUPPLY (COSTED REOULS.)  14.00  0 0	(COSTED REQUIS.)	RECORDS & LIBRARY (GROSS REVE NUE) 16.00 0 0	(TIME SPENT)  17.00  0 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	(FTES)  11. 00  1, 374  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0	SERVI CES & SUPPLY (COSTED REOULS.)  14.00  0 0 0	(COSTED REQUIS.)	RECORDS & LIBRARY (GROSS REVE NUE) 16.00 0 0 0	(TIME SPENT)  17.00  0 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	11. 00 1, 374 0 0 0 0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0	SERVI CES & SUPPLY (COSTED REQUIS.)  14.00  0 0 0 0	(COSTED REQUIS.)	RECORDS & LI BRARY (GROSS REVE NUE) 16. 00 0 0 0 0	(TIME SPENT)  17. 00  0 0 0 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	(FTES)  11. 00  1, 374  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG)  13. 00  28, 237  0  0 0 0	SERVI CES & SUPPLY (COSTED REQUI S.)  14. 00  0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0	RECORDS & LI BRARY (GROSS REVE NUE) 16. 00 0 0 0 0 0 0	(TIME SPENT)  17. 00  0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REQUI S.) 14.00 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0	RECORDS & LI BRARY (GROSS REVE NUE) 16. 00 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	11. 00 1, 374 0 0 0 0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REQUI S.)  14.00  0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)	RECORDS & LIBRARY (GROSS REVE NUE) 16.00 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REOULS.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LIBRARY (GROSS REVE NUE) 16.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REQUI S.)  14.00  0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LIBRARY (GROSS REVE NUE) 16.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0 0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REOULS.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LIBRARY (GROSS REVE NUE) 16.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0 0	ADMI NI STRATI ON  (DI RECT NRS I NG)  13. 00  28, 237  0  0  0  0  0  0  0  0  0  0  0	SERVI CES & SUPPLY (COSTED REOULS.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY (GROSS REVE NUE)  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG)  13. 00  28, 237  0  0  0  0  0  0  0  0  0  0  0  0  0	SERVI CES & SUPPLY (COSTED REOULS.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY (GROSS REVE NUE)  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG)  13. 00  28, 237  0  0  0  0  0  0  0  0  0  0  0  0  0	SERVICES & SUPPLY (COSTED REQUIS.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY (GROSS REVE NUE) 16. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG)  13. 00  28, 237  0  0  0  0  0  0  0  0  0  0  0  0  0	SERVICES & SUPPLY (COSTED REQUIS.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY (GROSS REVE NUE) 16. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVICES & SUPPLY (COSTED REOULS.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY (GROSS REVE NUE)  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG)  13. 00  28, 237  0  0  0  0  0  0  0  0  0  0  0  0  0	SERVICES & SUPPLY (COSTED REQUIS.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  00 00 00 00 00 00 00 00 00 00 00 00	RECORDS & LI BRARY (GROSS REVE NUE)  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REOUI S.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  00 00 00 00 00 00 00 00 00 00 00 00	RECORDS & LI BRARY (GROSS REVE NUE)  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVICES & SUPPLY (COSTED REOULS.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY (GROSS REVE NUE)  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17. 00  0  0  0  0  0  0  0  0  0  0  0  0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REOUI S.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY (GROSS REVE NUE) 16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REOUI S.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY (GROSS REVE NUE) 16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REOUI S.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  00 00 00 00 00 00 00 00 00 00 00 00	RECORDS & LI BRARY (GROSS REVE NUE) 16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) Total cost to be allocated	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REOUI S.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  00 00 00 00 00 00 00 00 00 00 00 00	RECORDS & LI BRARY (GROSS REVE NUE)  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	(FTES)  11. 00  1, 374  0  0  0  0  0  0  0  0  0  0  0  0  0	ADMI NI STRATI ON  (DI RECT NRS I NG) 13. 00 28, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY (COSTED REOUI S.)  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(COSTED REQUIS.)  15.00  00 00 00 00 00 00 00 00 00 00 00 00	RECORDS & LI BRARY (GROSS REVE NUE)  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(TIME SPENT)  17. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00

Heal th	Financial Systems		DEKALB MEMORI	AI HOSPITAI		In lie	eu of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST	S			CN: 15-0045	Peri od:	Worksheet H-3	
				HHA CCN:	15-7157	From 10/01/2015 To 09/30/2016		
				Title	e XVIII	Home Health Agency I	PPS	о рііі
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
			4 00	Part II)	2.00	4.00	4)	
	PART I - COMPUTATION OF LESSER	0	1.00	2.00	3.00	4. 00	5.00	
	BENEFICIARY COST LIMITATION	OF AGGREGATE F	YKUGKAW CUSI, A	GUREGATE OF TE	1E PRUGRAW LIN	ITATION COST, OF	₹ 	
1 00	Cost Per Visit Computation	2.00	854, 651		854.6	1 4 501	10/ 1/	1 00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	2. 00 3. 00		C			186. 16 159. 39	
3.00	Occupational Therapy	4. 00		(	1			
4.00	Speech Pathology	5. 00			2, 48			
5.00	Medical Social Services	6. 00			44, 2			
6.00	Home Heal th Aide	7. 00			355, 5			1
7. 00	Total (sum of lines 1-6)	7.00	1, 644, 747	,	1, 644, 7			7. 00
7.00	Total (Suil of Titles 1-0)		1,044,747		Program Visi			7.00
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
	oost denter bescription	OOST ETHIN ES	000/11/0. (1)	rui e n	Deducti bl es			
					Coi nsurance			
		0	1.00	2.00	3.00	4. 00	5. 00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		50031	C		32		8. 00
8. 01	Skilled Nursing Care		99915	C	1, 3:	22		8. 01
9. 00	Physi cal Therapy		50031	C	) 10			9. 00
9. 01	Physi cal Therapy		99915	C	5!	56		9. 01
10. 00	Occupational Therapy		50031	C	)	3		10.00
10. 01	Occupational Therapy		99915	C	1			10. 01
11.00	Speech Pathology		50031	(	1	14		11.00
11. 01	Speech Pathology		99915			12		11. 01
12.00	Medical Social Services		50031	(		4		12.00
12. 01	Medical Social Services Home Health Aide		99915 50031		1.	6		12. 01 13. 00
13. 00 13. 01	Home Health Aide		99915			10 27		13.00
	Total (sum of lines 8-13)		99913		3, 10			14. 00
14.00		From Wkst H_2	Facility Costs	Shared	Total HHA		Ratio (col. 3	14.00
	cost center bescription	Part I, col.	(from Wkst.	Ancillary	Costs (col s.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
			=,,	Part II)	'-/	,		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Computa	ations						
15. 00	The state of the s	8. 00		C		0		
16. 00	Cost of Drugs	9. 00		C	)	0 0	0. 000000	16. 00
			Program Visits		Cost of			
					Servi ces	D 1 D		
	C+ C+ D!!	D+ A	Par		D+ A	Part B	Culti and the	
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles & Coinsurance	Coinsurance		Deductibles & Coinsurance	Deductibles & Coinsurance	
		6.00	7. 00	8. 00	9.00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION	I. ACOMEDINE						
	Cost Per Visit Computation							1
1.00	Skilled Nursing Care	0	1, 754			0 326, 525		1.00
2.00	Physical Therapy	Ö				0 115, 239		2. 00
3.00	Occupational Therapy	0	117			0 41, 609		3. 00
4.00	Speech Pathology	0	26			0 788		4. 00
5.00	Medical Social Services	0	10			0 17, 018		5. 00
6.00	Home Health Aide	0	537			0 83, 842		6. 00
7.00	Total (sum of lines 1-6)	0	3, 167			0 585, 021		7. 00

n Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
TIONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 15-0045	Peri od:		3
			HHA CCN:	15-7157	To 09/30/2016	Date/Time Pre	
			Ti tl e	e XVIII	Home Health Agency I	PPS	о рііі
Cost Center Description	4.00	7.00	0.00	0.00		11 00	
Limitation Cost Computation	0.00	7.00	8.00	9.00	10.00	11.00	
Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 14. 00
lotal (sum of lines 8-13)	Prog	ram Covered Cha	irnes	Cost of			14. 00
	1139			Servi ces	Part R		
Cost Center Description	Part A	Not Subject to Deductibles &	Subject to Deductibles &	Part A	Not Subject to Deductibles & Coinsurance		
	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
		0	0	ı	0 0	(	15.00
Cost of Drugs		0		1	0	(	
·	Cost (sum of cols. 9-10)	-					
BENEFICIARY COST LIMITATION	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LI	MITATION COST, OR	<u> </u>	
Skilled Nursing Care							1.00
							2.00
							4.00
Medical Social Services							5. 00
· ·							6.00
	585, 021						7. 00
Tool Jones Book Prival	12. 00						
Limitation Cost Computation	T	T					
Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01
	Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)  Cost Center Description  Supplies and Drugs Cost Computation Cost of Medical Supplies Cost of Drugs Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Medical Social Services Medical Social Services	Limitation Cost Computation  Skilled Nursing Care Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)  Prog  Cost Center Description  Cost of Drugs  Cost Center Description  Part A  Supplies and Drugs Cost Computations Cost of Medical Supplies Cost Of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER OF AGGREGATE FROM Speech Pathology Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation  Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Physical Therapy Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Cocupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Home Health Aide Home Health Aide Home Health Aide Total (sum of lines 8-13)  Program Covered Cha  Cost Center Description  Part A Not Subject to Deductibles & Colnsurance 6.00 7.00  Supplies and Drugs Cost Computations Cost of Medical Supplies Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, A BENEFICIARY COST LIMITATION Cost Prysic Computation Skilled Nursing Care Physical Therapy Speech Pathology Medical Social Services Home Health Aide 83,842 Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Bathology Speech Pathology	Cost Center Description    Limitation Cost Computation   6.00   7.00   8.00	Cost Center Description   6.00   7.00   8.00   9.00	HAA CON: 15-7157   From 10/01/2015   From 10/0	HHA CCN

Heal th	Financial Systems		DEKALB MEMORI.	AL HOSPITAL	SPITAL In Lieu of Form CMS-25			
<b>APPORT</b>	TIONMENT OF PATIENT SERVICE COST	S		Provi der Co		Peri od:	Worksheet H-3	
				HHA CCN:	15-7157	From 10/01/2015 To 09/30/2016		
				Title	: XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
			provi der	Costs (col.	1 Indicated			
				records)	x col. 2)			
		0	1.00	2.00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		l
1.00	Physi cal Therapy	66. 00	0. 384536	0		0 col. 2, line 2	. 00	1. 00
1.01	Physical Therapy 1	66. 01	0. 982943	0		0 col. 2, line 2	. 01	1. 01
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3. 00
4.00	Cost of Medical Supplies	71. 00	0. 547100	0		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 621341	0		0 col. 2, line 1	6. 00	5. 00

.CUL	Financial Systems DEKALB MEMORIAL ATION OF HHA REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CC	N: 15-0045	Peri o	d:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7157		10/01/2015 09/30/2016	Part I-II Date/Time Pre 2/23/2017 4:5	
		Title	XVIII		e Health gency I	PPS	
						t B	
			Part A		Subject to	Subject to Deductibles &	
					i nsurance	Coi nsurance	
			1. 00	001	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGES	5				
_	Reasonable Cost of Part A & Part B Services					0	١,
0	Reasonable cost of services (see instructions) Total charges			0	0		
U	Customary Charges			O <sub>I</sub>		0	1
0	Amount actually collected from patients liable for payment for	servi ces		0	0	0	] 3
	on a charge basis (from your records)						
0	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0	0	0	4
0	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00	0.000000	0. 000000	1
0	Total customary charges (see instructions)			0	0	0	
0	Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1)	complete		0	0	0	-
0	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0	0	0	
)	Primary payer amounts			0	0	0	١ (
					Part A	Part B	
				5	Servi ces 1. 00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			I	1.00	2.00	
00	Total reasonable cost (see instructions)				0	0	10
00	Total PPS Reimbursement - Full Episodes without Outliers				0	428, 165	
00	Total PPS Reimbursement - Full Episodes with Outliers				0	8, 541	
00	Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes				0	10, 912 3, 397	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	3, 397 1, 162	
00	Total PPS Outlier Reimbursement - PEP Episodes				0	0	
00	Total Other Payments				0	0	1
00	DME Payments				0	0	
00	Oxygen Payments				0	0	
00	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu	irance)			0	0	1 -
00	Subtotal (sum of lines 10 thru 20 minus line 21)				0	452, 177	
00	Excess reasonable cost (from line 8)				0	132, 177	
00	Subtotal (line 22 minus line 23)				0	452, 177	
00	Coinsurance billed to program patients (from your records)					0	
00	Net cost (line 24 minus line 25)				0	452, 177	
00	Reimbursable bad debts (from your records)	netrueti ana					2
00	Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line				0	452, 177	2
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. 21)			0	432, 177	
50	Pioneer ACO demonstration payment adjustment (see instructions	s)			0	0	
00	Subtotal (see instructions)				0	452, 177	
01	Sequestration adjustment (see instructions)				0	9, 044	
00	Interim payments (see instructions)				0	443, 134	
	Tentative settlement (for contractor use only)				0	0	
00		and 22)			^		
00 00 00	Balance due provider/program (line 31 minus lines 31.01, 32, a Protested amounts (nonallowable cost report items) in accordan	,	Pub 15-2		0	-1 0	3:

DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems DEKALB MEMORIA
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES Peri od: From 10/01/2015 To 09/30/2016 Date/Time Prepared: 2/23/2017 4:56 pm PPS Provider CCN: 15-0045 HHA CCN: 15-7157

				Home Health Agency I	PPS	<u> </u>
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	443, 134 0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3.01				0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
3. 50	Provider to Program		I	ol	0	3. 50
3. 50				0		3. 50
3. 52				Ö		3. 52
3. 53				0	l ol	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	443, 134	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01				0	0	5. 01
5. 02				0	0	5. 02
5. 03	Provider to Program			0	U	5. 03
5. 50	Frovider to Frogram			ol	0	5. 50
5. 51				o	l ol	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM   Total Medicare program liability (see instructions)			0	443, 133	6. 02 7. 00
7.00	Total medicare program trability (see ilistructions)			Contractor Number	NPR Date (Mo/Day/Yr)	7.00
			)	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Provider CCN: 15-0045 Peri od: From 10/01/2015 To 09/30/2016 Worksheet 0 Date/Time Prepared: 2/23/2017 4:56 pm Hospi ce CCN: 15-1559

					11! 1	2/23/2017 4.3	o piii
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 plus col. 2)	CATI ONS		
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT*		C	0	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	o	0	0	2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	12, 719	12, 719	0	12, 719	3. 00
4.00	ADMINISTRATIVE & GENERAL*		179, 006		571	179, 577	4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	617	617	5/1	617	5. 00
		0	017	1	0		
6.00	LAUNDRY & LINEN SERVICE*	0	U	0	U	0	6. 00
7.00	HOUSEKEEPI NG*	0	0	0	0	0	7. 00
8.00	DI ETARY*	0	3, 628	3, 628	0	3, 628	8. 00
9.00	NURSI NG ADMI NI STRATI ON*	0	0	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDI CAL RECORDS*	0	0	0	0	0	11. 00
12.00	STAFF TRANSPORTATION*	ol	9, 234	9, 234	0	9, 234	12. 00
13.00	VOLUNTEER SERVICE COORDINATION*	ol	. 0	0	0	0	13. 00
14. 00	PHARMACY*	0	0	ا	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*		0		0	0	15. 00
16. 00	OTHER GENERAL SERVICE*	0	0		0	0	16. 00
		۷	U	١	U	U	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS			1 _1	_	_	
25. 00	INPATIENT CARE-CONTRACTED**	0	0	· ·	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES**	5, 261	0	5, 261	0	5, 261	26. 00
27. 00	NURSE PRACTITIONER**	0	0	0	0	0	27. 00
28.00	REGI STERED NURSE**	62, 806	0	62, 806	0	62, 806	28. 00
29. 00	LPN/LVN**	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY**	140	0	140	0	140	30. 00
31.00	OCCUPATIONAL THERAPY**	ol	0	0	0	0	31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	149	0	149	0	149	33. 00
34. 00	SPIRITUAL COUNSELING**	5, 157	0		0	5, 157	34. 00
35. 00	DI ETARY COUNSELI NG**	3, 137	0	3, 137	0	0, 137	35. 00
36. 00	COUNSELING - OTHER**	0	0		0	0	36.00
		1 "	U	( 050	0	_	
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	6, 058	U	6, 058	0	6, 058	37. 00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	Ü	0	0	0	38. 00
39. 00	PATI ENT TRANSPORTATI ON**	0	0	0	0	0	39. 00
40.00	I MAGI NG SERVI CES**	353	0	353	0	353	40. 00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41. 00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	ol	0	o	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY**	o	0	o	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	o	0	0	0	0	46. 00
	NONREI MBURSABLE COST CENTERS	-1	<del>-</del>	-1	-		
60. 00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM *		Ö		0	0	61. 00
62. 00	FUNDRAI SI NG*		0		0	0	62.00
		0	U	0	0		
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	U	0	0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES*	0	0	ا 0	0	0	65. 00
66.00	RESI DENTI AL CARE*	0	0	0	0	0	66. 00
67.00	ADVERTI SI NG*	0	0	0	0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG*		0	o	0	0	68. 00
69.00	THRIFT STORE*	ol	0	ol	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD*		0	o	0	0	70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71. 00
100.00		79, 924	205, 204	285, 128	571	285, 699	100.00
100.00	TOTAL	17,724	200, 204	200, 120	371	203, 077	100.00

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

				Hospi ce I	2/23/2017 4.	оо рііі
		ADJUSTMENTS	TOTAL (col. 5	<u>'                                    </u>		
			± col. 6)			
		6. 00	7. 00			
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT*	0	0			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0			2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	12, 719			3. 00
4.00	ADMINISTRATIVE & GENERAL*	-173	179, 404			4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	617			5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0			6. 00
7.00	HOUSEKEEPI NG*	0	0			7. 00
8.00	DI ETARY*	0	3, 628			8. 00
9.00	NURSI NG ADMI NI STRATI ON*	0	0			9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0			10.00
11. 00	MEDI CAL RECORDS*	0				11. 00
12. 00	STAFF TRANSPORTATION*	0				12. 00
13. 00	VOLUNTEER SERVICE COORDINATION*	0				13. 00
14. 00	PHARMACY*	0				14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*					15. 00
16. 00	OTHER GENERAL SERVICE*					16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES					17. 00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS					17.00
25. 00	INPATIENT CARE-CONTRACTED**	0	0			25. 00
26. 00	PHYSI CI AN SERVI CES**	0				26. 00
27. 00	NURSE PRACTITIONER**					27. 00
28. 00	REGI STERED NURSE**					28. 00
29. 00	LPN/LVN**					29. 00
30. 00	PHYSICAL THERAPY**					30.00
31. 00	OCCUPATIONAL THERAPY**					31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY**					32.00
32.00						
	MEDICAL SOCIAL SERVICES**	0				33. 00
34.00	SPIRITUAL COUNSELING**	0				34.00
35. 00	DI ETARY COUNSELI NG**	0				35. 00
36.00	COUNSELING - OTHER**	0				36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0				37. 00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0				38. 00
39. 00	PATI ENT TRANSPORTATI ON**	0				39. 00
40. 00	I MAGING SERVI CES**	0				40. 00
41. 00	LABS & DIAGNOSTICS**	0				41. 00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0				42. 00
43. 00	OUTPATIENT SERVICES**	0				43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	0				44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	0				45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0			46. 00
	NONREI MBURSABLE COST CENTERS	_	1			<b>-</b>
60.00	BEREAVEMENT PROGRAM *	0				60.00
61. 00	VOLUNTEER PROGRAM *	0				61. 00
62. 00	FUNDRAI SI NG*	0				62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0				63. 00
64. 00	PALLIATIVE CARE PROGRAM*	0				64. 00
65. 00	OTHER PHYSI CI AN SERVI CES*	0	_			65. 00
66. 00	RESI DENTI AL CARE*	0				66. 00
67. 00	ADVERTI SI NG*	0				67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0			68. 00
69. 00	THRI FT STORE*	0	0			69. 00
70.00	NURSING FACILITY ROOM & BOARD*	0	0			70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0			71. 00
100.00		-173	285, 526	 		100.00
	·					

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

CARE

Worksheet 0-2

Peri od: From 10/01/2015 To 09/30/2016 Date/Time Prepared: 2/23/2017 4:56 pm Hospi ce CCN: 15-1559 Hospi ce I

		SALARI ES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI - CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	1.22					
25.00	INPATIENT CARE-CONTRACTED						25. 00
26. 00	PHYSI CI AN SERVI CES	5, 165	C	5, 165	0	5, 165	26. 00
27. 00	NURSE PRACTITIONER	0	C	0	0	0	27. 00
28. 00	REGI STERED NURSE	61, 669	C	61, 669	0	61, 669	28. 00
29. 00	LPN/LVN	0	C	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	C	0	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	C	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	C	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	C	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	5, 063	C	5, 063	0	5, 063	34.00
35.00	DI ETARY COUNSELING	0	C	0	0	0	35.00
36.00	COUNSELING - OTHER	0	C	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	5, 948	C	5, 948	0	5, 948	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	C	0	0	0	38. 00
39. 00	PATIENT TRANSPORTATION	0	C	0	0	0	39. 00
40.00	I MAGI NG SERVI CES	0	C	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	C	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	C	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	C	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	C	0	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	C	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	C	0	0	0	46.00
100.00	TOTAL *	77, 845		77, 845	0	77, 845	100.00
* Transfer the amount in column 7 to Wkst. 0-5. column 1. Line 51.							

Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6.00	7. 00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED				25. 00
26.00	PHYSI CI AN SERVI CES	0	5, 165		26.00
27.00	NURSE PRACTITIONER	0	0		27. 00
28.00	REGI STERED NURSE	0	61, 669		28. 00
29.00	LPN/LVN	0	0		29. 00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATI ONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPI RI TUAL COUNSELI NG	0	5, 063		34.00
35.00	DI ETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	5, 948		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38. 00
39.00	PATI ENT TRANSPORTATION	0	0		39. 00
40.00	I MAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	77, 845	1	100.00

 $<sup>^{\</sup>star}$  Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

RESPITE CARE

Hospi ce CCN: 15-1559

Peri od: Worksheet 0-3 From 10/01/2015 To 09/30/2016

Date/Time Prepared: 2/23/2017 4:56 pm

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	I NPATIENT CARE-CONTRACTED	0	0	0	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	8	0	8	0	8	26. 00
27. 00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00	REGI STERED NURSE	92	0	92	0	92	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31. 00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33. 00
34.00	SPIRITUAL COUNSELING	8	0	8	0	8	34.00
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	9	0	9	0	9	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGI NG SERVI CES	0	0	0	0	0	40. 00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100.00	TOTAL *	117	0	117	0	117	100.00
* Transfor the amount in column 7 to Wket 0.5 column 1. Line 52							

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	8	26. 00
27.00	NURSE PRACTITIONER	0	0	27. 00
28.00	REGI STERED NURSE	0	92	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	0	33. 00
34.00	SPIRITUAL COUNSELING	0	8	34. 00
35.00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	9	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38. 00
39.00	PATI ENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42. 00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	117	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

INPATIENT CARE

Peri od: Worksheet 0-4 From 10/01/2015 To 09/30/2016

Date/Time Prepared: 2/23/2017 4:56 pm Hospi ce CCN: 15-1559

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	88	0	88	0	88	26. 00
27. 00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00	REGI STERED NURSE	1, 045	0	1, 045	0	1, 045	28. 00
29. 00	I '	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	140	0	140	0	140	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	0 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	149	0	149	0	149	33. 00
34.00	SPI RI TUAL COUNSELI NG	86	0	86	0	86	34. 00
35. 00	DI ETARY COUNSELING	0	0	0	0	0	35. 00
36.00		0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	101	0	101	0	101	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38. 00
39. 00	PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGING SERVICES	353	0	353	0	353	40. 00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42. 00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43. 00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100.00	TOTAL *	1, 962	0	1, 962	0	1, 962	100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	AD ILICTMENTS	TOTAL (1 E		
	ADJUSTMENTS	TOTAL (col. 5		
	/ 00	± col. 6)		
DUDECT DATIENT CADE CEDVICE COCT CENTEDO	6. 00	7. 00		
DI RECT PATIENT CARE SERVICE COST CENTERS	1			05 00
25. 00 I NPATI ENT CARE-CONTRACTED		0	•	25. 00
26. 00 PHYSI CI AN SERVI CES		88		26. 00
27. 00 NURSE PRACTITIONER	C	0	·	27. 00
28. 00 REGI STERED NURSE	C	1, 045		28. 00
29. 00   LPN/LVN	C	0	l l	29. 00
30. 00 PHYSI CAL THERAPY	C	140		30.00
31. 00 OCCUPATI ONAL THERAPY	C	0		31.00
32.00   SPEECH/LANGUAGE PATHOLOGY	C	0		32.00
33.00 MEDICAL SOCIAL SERVICES	C	149		33.00
34.00 SPIRITUAL COUNSELING	C	86		34.00
35. 00 DI ETARY COUNSELING	C	o		35.00
36. 00 COUNSELING - OTHER		o		36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	l c	101		37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00 PATIENT TRANSPORTATION		ol		39.00
40. 00 I MAGI NG SERVI CES		353		40.00
41.00 LABS & DIAGNOSTICS		l ol		41.00
42.00 MEDICAL SUPPLIES-NON-ROUTINE		o		42.00
43. 00 OUTPATIENT SERVICES	i c	o		43. 00
44. 00 PALLIATIVE RADIATION THERAPY		أم		44. 00
45. 00 PALLI ATI VE CHEMOTHERAPY		l o	•	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)		ا		46. 00
100. 00 TOTAL *		1, 962		100.00
100.00 1017.2		1, 702		100.00

 $<sup>^{\</sup>star}$  Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Heal th	Financial Systems DEKALB MEMORIA	N HOSPLTAL		In lie	eu of Form CMS-2	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C	CN: 15-0045	Peri od:	Worksheet 0-5	
	ES FOR ALLOCATION			From 10/01/2015		
2711 2110	ES TON NEEDSTITON	Hospi ce CC	N: 15-1559	To 09/30/2016		
					2/23/2017 4:5	6 pm
			UOCDI OF DI DEO	Hospi ce I	TOTAL EVENUES	
	Descri pti ons		HOSPICE DIREC		TOTAL EXPENSES	
			EXPENSES (see		(sum of cols.	
			instructions)	WKST B PART I	1 + 2)	
				(see		
				instructions)		
			1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT			0 281	281	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP			0 0	0	2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT		12, 71		14, 699	3. 00
4. 00	ADMINISTRATIVE & GENERAL		179, 40		232, 986	4. 00
5. 00	PLANT OPERATION & MAINTENANCE		61		10, 116	5. 00
6. 00	LAUNDRY & LINEN SERVICE		•	0 61	61	6. 00
7. 00	HOUSEKEEPING			0 3, 039	3, 039	7. 00
8. 00	DIETARY		3, 62		3, 628	8.00
9.00	NURSING ADMINISTRATION			0 9, 367	9, 367	9.00
10. 00	ROUTINE MEDICAL SUPPLIES			0 7, 307	9, 307	10.00
11. 00	MEDICAL RECORDS		1	0 4, 564	4, 564	11. 00
12. 00	STAFF TRANSPORTATION		9, 23		9, 234	12.00
13. 00	VOLUNTEER SERVICE COORDINATION			0	9, 234	13. 00
14. 00	PHARMACY		i e	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	15. 00
16. 00	OTHER GENERAL SERVICE			0 0	ľ	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
17.00	LEVEL OF CARE			0	0	17.00
50. 00	HOSPICE CONTINUOUS HOME CARE			ol	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE		77, 84		77, 845	
52. 00	HOSPICE INPATIENT RESPITE CARE		11		117	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE		1, 96		1, 962	53. 00
33.00	NONREI MBURSABLE COST CENTERS		1, 70	۷	1, 702	33.00
60.00	BEREAVEMENT PROGRAM			ol	0	60.00
61. 00	VOLUNTEER PROGRAM		•	o	0	61.00
62. 00	FUNDRAI SI NG		•	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64. 00	PALLI ATI VE CARE PROGRAM			o	0	64.00
65. 00	OTHER PHYSI CI AN SERVI CES			Ö	0	65. 00
44.00	DECLERATION SERVICES		1	-	1	(( 00

82, 373

285, 526

66. 00 67. 00

68. 00

0 69.00 0 70.00

0 71.00

99. 00

367, 899 100. 00

66. 00 RESI DENTI AL CARE
67. 00 ADVERTI SI NG

100. 00 TOTAL

68. 00 | TELEHEALTH/TELEMONI TORI NG

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD

71. 00 OTHER NONREIMBURSABLE (SPECIFY)
99. 00 NEGATIVE COST CENTER

 
 Heal th Financial
 Systems
 DEKALB MEMO

 COST ALLOCATION
 - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
 

			nospi ce cci	V. 13-1337	10 07/30/2010	2/23/2017 4:5	
					Hospi ce I		
	Descriptions	TOTAL EXPENSES CA	P REL BLDG &	CAP REL MVBL		SUBTOTAL	
	<b>'</b>		FLX	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1. 00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	281	281				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	14, 699	0		0 14, 699		3. 00
4.00	ADMINISTRATIVE & GENERAL	232, 986	0		0	232, 986	4. 00
5.00	PLANT OPERATION & MAINTENANCE	10, 116	0		0	10, 116	5. 00
6.00	LAUNDRY & LINEN SERVICE	61	0		0	61	6. 00
7.00	HOUSEKEEPI NG	3, 039	0		0 0	3, 039	7. 00
8.00	DI ETARY	3, 628	0		0 0	3, 628	8. 00
9.00	NURSI NG ADMI NI STRATI ON	9, 367	0		0 0	9, 367	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	0	10.00
11.00	MEDI CAL RECORDS	4, 564	0		0 0	4, 564	11. 00
12.00	STAFF TRANSPORTATION	9, 234	0		0 0	9, 234	
13.00	VOLUNTEER SERVICE COORDINATION		0		0 0	0	13. 00
14. 00	PHARMACY	o	0		0 0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	o	0		0 0	0	15. 00
16, 00	OTHER GENERAL SERVICE	o	0		0 0	0	16, 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0		0	0	17. 00
	LEVEL OF CARE	· · · · · · · · · · · · · · · · · · ·			-1		
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	77, 845			14, 432	92, 277	51. 00
52.00	HOSPICE INPATIENT RESPITE CARE	117	22		0 22	161	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 962	259		0 245	2, 466	53. 00
	NONREI MBURSABLE COST CENTERS			•	•		
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61. 00
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63. 00
64.00	PALLIATIVE CARE PROGRAM	O	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	O	0		0 0	0	65. 00
66.00	RESI DENTI AL CARE	o	0		0 0	0	66. 00
67.00	ADVERTI SI NG	O	0		0 0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	o	0		0 0	0	68. 00
69.00	THRI FT STORE	o	0		0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD	o				0	70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	l ol	0		0	Ō	71. 00
99. 00	NEGATIVE COST CENTER	l	0		0 0		99. 00
100.00	4	367, 899	281		0 14, 699	367, 899	
	1	1		1	., ., .,		

 
 Heal th Financial
 Systems
 DEKALB MEMO

 COST ALLOCATION
 - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
 Provider CCN: 15-0045 Hospi ce CCN: 15-1559

					Hospi ce I	272072017 1.0	<u> </u>
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	besci i pti ons	& GENERAL	OPERATION &	LINEN SERVICE	HOUSEKEELLING	DILIANI	
		d OLIVLIAL	MAI NTENANCE	LINEN SERVICE			
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS				,		
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	232, 986					4. 00
5.00	PLANT OPERATION & MAINTENANCE	17, 470	27, 586				5. 00
6.00	LAUNDRY & LINEN SERVICE	105	. 0	1	,		6. 00
7.00	HOUSEKEEPING	5, 248	0		8, 287		7. 00
8.00	DI ETARY	6, 265	0		0	9, 893	8. 00
9.00	NURSI NG ADMI NI STRATI ON	16, 176	0		O		9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11. 00	MEDI CAL RECORDS	7, 882	0		0		11. 00
12.00	STAFF TRANSPORTATION	15, 947	0		0		12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14. 00	PHARMACY	0	0		0		14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15. 00
16. 00	OTHER GENERAL SERVICE	0	0		0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17. 00
	LEVEL OF CARE			•	'		1
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	159, 356					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	278	2, 207	16	663	957	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	4, 259	25, 379	150	7, 624	8, 936	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	O		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61. 00
62.00	FUNDRAI SI NG	0	0		0		62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	)	0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	)	0		65.00
66.00	RESI DENTI AL CARE	0	0	0	0	0	66. 00
67.00	ADVERTI SI NG	0	0	)	0		67.00
68.00	TELEHEALTH/TELEMONI TORI NG	O	0	)	0		68. 00
69.00	THRI FT STORE	0	0	)	0		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	o	0	71. 00
99. 00	NEGATIVE COST CENTER	0	0	0	o	0	99. 00
100.00	TOTAL	232, 986	27, 586	166	8, 287	9, 893	100.00
		·			·		

Heal th	Financial Systems	DEKALB MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der CC		Peri od:	Worksheet 0-6	
					From 10/01/2015	Part I	
			Hospi ce CCN	N: 15-1559	To 09/30/2016	Date/Time Pre	
-					Hospi ce I	2/23/2017 4:50	o pm
	D	NUDCLNC	DOUTLNE	MEDICAL		VOLUNTEED	
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	
		0.00	SUPPLI ES	11 00	12.00	COORDI NATI ON	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	12.00	13. 00	
1 00	CAP REL COSTS-BLDG & FIXT						1. 00
1.00							
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE	1					5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION	25, 543					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDI CAL RECORDS	0		12, 44	6		11.00
12.00	STAFF TRANSPORTATION	O			25, 181		12.00
13.00	VOLUNTEER SERVICE COORDINATION	o			0	0	13.00
14.00	PHARMACY	o			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	o			0	0	15.00
16.00	OTHER GENERAL SERVICE	ol			o	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES					-	17. 00
	LEVEL OF CARE	· ·					
50.00	HOSPI CE CONTI NUOUS HOME CARE	0	0		0 0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	25, 079	0	12, 16	4 25, 181	0	51. 00
52. 00	HOSPICE INPATIENT RESPITE CARE	36	0		7 0	0	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	428	0	25		0	53. 00
00.00	NONREI MBURSABLE COST CENTERS	.25	٥,	20		5	00.00
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61. 00	VOLUNTEER PROGRAM	0			0	0	61. 00
62. 00	FUNDRAI SI NG	o o			0	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM				0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES				0	0	65. 00
66. 00	RESIDENTIAL CARE				0	0	66. 00
		0			0	-	
67. 00	ADVERTI SI NG	0				0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69. 00	THRI FT STORE	0			0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD	_			_	_	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	_		0	0	71. 00
99. 00		0	0		U 0	0	99. 00
100.00	TOTAL	25, 543	0	12, 44	6 25, 181	0	100. 00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0045 Peri od: Worksheet 0-6 From 10/01/2015 Part I Hospi ce CCN: 15-1559 09/30/2016 Date/Time Prepared: 2/23/2017 4:56 pm Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI VE SERVI CE RESI DENTI AL SERVI CES CARE SERVICES 14. 00 16. 00 18.00 15.00 17.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 50.00 0 HOSPICE ROUTINE HOME CARE 0 0 314, 057 51.00 51.00 HOSPICE INPATIENT RESPITE CARE 0 0 4, 345 52.00 0 52.00 0 0 53.00 HOSPICE GENERAL INPATIENT CARE 49, 497 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 n 60.00 0 0 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 61.00 0 61.00 62.00 FUNDRAI SI NG 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 63.00 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 0 66.00 67 00 ADVERTISING 0 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 0 70.00

0 0

0

0

0

0

71.00 Ω

0 99.00

367, 899 100. 00

71 00

100.00 TOTAL

OTHER NONREIMBURSABLE (SPECIFY)

99.00 NEGATIVE COST CENTER

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERA STATISTICAL BASIS	L SERVICE COSTS	Provider CCN:	Peri od: From 10/01/2015 To 09/30/2016	Worksheet 0-6 Part II Date/Time Prepared: 2/23/2017 4:56 pm

			Hospice CCN	l: 15-1559   T	o 09/30/2016	Date/Time Pre 2/23/2017 4:5	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG & C FIX (SQUARE FEET) (E	EQUI P	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCI LI ATI ON	ADMI NI STRATI VE & GENERAL (ACCUMULATED COSTS)	
		1.00	2. 00	3. 00	4A	4. 00	
-	GENERAL SERVICE COST CENTERS		'				
1.00	CAP REL COSTS-BLDG & FLXT	300					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	O	0	79, 924	ļ i		3.00
4.00	ADMINISTRATIVE & GENERAL	O	0	C	-232, 986	134, 913	4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	0	C	o	10, 116	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	C	o	61	6. 00
7.00	HOUSEKEEPI NG	0	0	C	o	3, 039	7. 00
8.00	DI ETARY	0	0	(	o	3, 628	8. 00
9.00	NURSING ADMINISTRATION	0	0	C	o	9, 367	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	(	o	0	10.00
11.00	MEDI CAL RECORDS	0	0	(	o	4, 564	11. 00
12.00	STAFF TRANSPORTATION	0	0	(	o	9, 234	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	(	o	0	13. 00
14.00	PHARMACY	0	0	(	o	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	(	o	0	15. 00
16.00	OTHER GENERAL SERVICE	0	0	(	o	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			C	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			78, 477	0	92, 277	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	24	0	117	0	161	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	276	0	1, 330	0	2, 466	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	(	0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	0	(	0	0	61. 00
62.00	FUNDRAI SI NG	0	0	C	0	0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	C	0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM	0	0	C	0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	0	C	0	0	65. 00
66. 00	RESI DENTI AL CARE	0	0	C	0	0	66. 00
67. 00	ADVERTI SI NG	0	0	C	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	C	0	0	68. 00
69. 00	THRI FT STORE	0	0	C	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD				0		70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	C	이	0	71. 00
99. 00	NEGATI VE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part	· 1	0	14, 699		232, 986	
101.00	UNIT COST MULTIPLIER	0. 936667	0. 000000	0. 183912	<u>'</u>	1. 726935	101.00

Heal th	Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der C		Peri od: From 10/01/2015	Worksheet 0-6 Part II	
STATES	TICAL BASIS		Hospi ce CCI		To 09/30/2016		
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	) (IN-FACILITY	ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY		DAYS)		
		(SQUARE FEET)	DAYS)			(DIRECT NURS.	
						HRS. )	
		5.00	6.00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	300					5.00
6 00	LAUNDRY & LINEN SERVICE	1 0	93				6 00

Health Financial Systems	DEKALB MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENER STATISTICAL BASIS	AL SERVICE COSTS	Provider CCN:	Peri od: From 10/01/2015 To 09/30/2016	Worksheet 0-6 Part II Date/Time Prepared: 2/23/2017 4:56 pm
			Hospi ce I	

3171113	TONE BIOLO		Hospi ce CCI	N: 15-1559	To 09/30/2016	Date/Time Pre 2/23/2017 4:5	
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATIO (MILEAGE)	VOLUNTEER N SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	PHARMACY (CHARGES)	
		10.00	11. 00	12.00	13. 00	14.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	10.00	1 00	
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	4 405					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	4, 105	4 105				10.00
11. 00	MEDICAL RECORDS STAFF TRANSPORTATION		4, 105	10			11.00
12. 00 13. 00	VOLUNTEER SERVICE COORDINATION				0 0		12. 00 13. 00
14. 00	PHARMACY				0	0	1
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES						
16. 00	OTHER GENERAL SERVICE					1	1
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE	'			<b>'</b>		
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	4, 012	4, 012	10	0	0	51. 00
52.00	HOSPICE INPATIENT RESPITE CARE	9	9		0	0	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	84	84		0 0	0	53. 00
	NONREI MBURSABLE COST CENTERS			ı			
60.00	BEREAVEMENT PROGRAM				0	1	1
61.00	VOLUNTEER PROGRAM				0	1	
62. 00 63. 00	FUNDRAL SI NG				0		02.00
64. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM				0 0	0	
65. 00	OTHER PHYSICIAN SERVICES						
66. 00	RESI DENTI AL CARE						1
67. 00	ADVERTI SI NG					0	1
68. 00	TELEHEALTH/TELEMONI TORI NG				0 0	0	1
69. 00	THRI FT STORE				o o	ĺ	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)				0 0	0	71. 00
99. 00	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	12, 446				100. 00
101.00	UNIT COST MULTIPLIER	0. 000000	3. 031912	251. 81000	0. 000000	0. 000000	101. 00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENI STATISTICAL BASIS	ERAL SERVICE COSTS	Provider CCN Hospice CCN:	From 10/01/2015	Worksheet 0-6 Part II Date/Time Prepared: 2/23/2017 4:56 pm

						2/23/2017 4:5	56 pm
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
	<b>'</b>	ADMI NI STRATI VE	SERVI CE	RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICES			
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
				DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
	1						•
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSI NG ADMINI STRATI ON						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES						10. 00
11. 00	MEDI CAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12. 00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14.00	PHARMACY						14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	4, 105					15. 00
16.00	OTHER GENERAL SERVICE		C				16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			93			17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	C	)			50. 00
51.00	HOSPICE ROUTINE HOME CARE	4, 012	l c				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	9		) 9	1		52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	84	l c	84			53.00
	NONREI MBURSABLE COST CENTERS				I		
60.00	BEREAVEMENT PROGRAM		C				60.00
61. 00	VOLUNTEER PROGRAM		ĺ	1			61. 00
62. 00	FUNDRAI SI NG		l d	1			62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		ľ				63. 00
	PALLIATIVE CARE PROGRAM						64. 00
65. 00	OTHER PHYSICIAN SERVICES						65. 00
66. 00	RESI DENTI AL CARE	0		ol c			66.00
67. 00	ADVERTI SI NG			d -			67. 00
68. 00							•
	TELEHEALTH/TELEMONI TORI NG	1		(			68.00
	THRIFT STORE			ή			69. 00
	NURSING FACILITY ROOM & BOARD						70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	C	) C	'		71.00
	NEGATI VE COST CENTER	_	_				99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	)	'		100.00
101. 00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.000000	1		101. 00

Heal th	Financial Systems	DEKALB MEMORIA	AI HOSPITAI		In lie	u of Form CMS-:	2552-10
APPOR1	TIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV OF CARE		Provi der CC Hospi ce CCN		Peri od: From 10/01/2015 To 09/30/2016	Worksheet 0-7	pared:
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, ( Part I, Col. 9 line	Cost to Charge Ratio	НСНС	HRHC	HI RC	
		0	1.00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66. 00	0. 384536		0 0	0	
1. 01	CARDI AC REHAB	66. 01	0. 982943		0	0	1
2.00	OCCUPATIONAL THERAPY	67. 00					2. 00
3.00	SPEECH PATHOLOGY DRUGS CHARGED TO PATIENTS	68.00	0 (01041				3.00
4. 00 5. 00	DURABLE MEDICAL EQUIP-RENTED	73. 00 96. 00	0. 621341		0 0	0	4. 00 5. 00
6. 00	LABORATORY	60.00	0. 205837			0	1
6. 00	BLOOD LABORATORY	60. 00	0. 205837		0	0	
7. 00	MEDICAL SUPPLIES CHARGED TO PAT	71. 00	0. 547100			0	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	0. 547 100		0	U	8.00
9.00	RADI OLOGY-THERAPEUTI C	55. 00					9. 00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11. 00		70.00					11.00
		Charges by LOC (from Provider Records)		Shared Servi	ce Costs by LOC		
	Cost Center Descriptions		HCHC (col 1 x	HRHC (col 1	xHIRC (col. 1 x	HGIP (col 1 x	
	oust deliter bescriptions	11011	col. 2)	col . 3)	col . 4)	col . 5)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	ANCILLARY SERVICE COST CENTERS				<u> </u>		
1.00	PHYSI CAL THERAPY	0	0		0 0	0	
1.01	CARDI AC REHAB	0	0		0	0	1
2.00	OCCUPATI ONAL THERAPY						2. 00
3.00	SPEECH PATHOLOGY						3. 00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0	0	4.00

5.00

6.00

6. 01

7. 00

8.00

9. 00 10. 00

0 11.00

0

0

5.00

6.00

6. 01

7.00

8.00

DURABLE MEDICAL EQUIP-RENTED

9. 00 RADI OLOGY-THERAPEUTI C
10. 00 OTHER ANCI LLARY SERVI CE COST CENTERS

MEDICAL SUPPLIES CHARGED TO PAT OTHER OUTPATIENT SERVICE COST CENTER

LABORATORY

BLOOD LABORATORY

11.00 Totals (sum of lines 1-11)

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST		Provi der CCN:	15-0045	Peri od: From 10/01/2015	Worksheet 0-8

COLATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0045 | Period: From 10/01/2015 | To 09/30/2016 | Date/Time Prepared: 2/23/2017 4:56 pm

					2/23/201/ 4.30	o piii
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col	. 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)		(	0		4.00
5.00	Program cost (line 3 times line 4)		(	0		5.00
	HOSPICE ROUTINE HOME CARE	•				ĺ
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col	. 7,			314, 057	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				4, 012	7.00
8.00	Total average cost per diem (line 6 divided by line 7)				78. 28	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	)	2, 889	87		9.00
10.00	Program cost (line 8 times line 9)		226, 151	6, 810		10.00
	HOSPICE INPATIENT RESPITE CARE					ĺ
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col	. 8,			4, 345	11.00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				9	12.00
13.00	Total average cost per diem (line 11 divided by line 12)				482. 78	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	)	Ç	0		14.00
15.00	Program cost (line 13 times line 14)		4, 345	0		15. 00
	HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col	. 9,			49, 497	16.00
	line 11)					
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				84	
18.00	Total average cost per diem (line 16 divided by line 17)				589. 25	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	)	52	16		19.00
20.00	Program cost (line 18 times line 19)		30, 641	9, 428		20.00
	TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				367, 899	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				4, 105	22.00
23.00	Average cost per diem (line 21 divided by line 22)				89. 62	23.00

Heal th	Financial Systems DEKALB MEMORIA	I HOSPITAI	In lie	u of Form CMS-2	2552-10	
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0045	Peri od: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Prep 2/23/2017 4:50	pared:	
	PPS					
				4 00		
	PART I - FULLY PROSPECTIVE METHOD			1. 00		
	CAPITAL FEDERAL AMOUNT					
1. 00	Capital DRG other than outlier			271, 045	1.00	
1. 01	Model 4 BPCI Capital DRG other than outlier			271,010	1. 01	
2.00	Capital DRG outlier payments			1, 070	2.00	
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01	
3.00	Total inpatient days divided by number of days in the cost r	reporting period (see inst	ructions)	17. 92	ł	
4.00	Number of interns & residents (see instructions)			0. 00	4. 00	
5. 00	Indirect medical education percentage (see instructions)			0. 00		
6. 00	Indirect medical education adjustment (multiply line 5 by th 1.01) (see instructions)	ne sum of lines 1 and 1.01	, columns 1 and	0	6. 00	
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet E	, part A line	0.00	7. 00	
8.00	Percentage of Medicaid patient days to total days (see instr	ructions)		0.00	8. 00	
9.00	Sum of lines 7 and 8	,		0.00	9. 00	
10.00	Allowable disproportionate share percentage (see instruction	ns)		0.00	10. 00	
11. 00	Disproportionate share adjustment (see instructions)			0	11. 00	
12. 00	Total prospective capital payments (see instructions)			272, 115	12. 00	
				1 00		
	DART II DAVMENT UNDER REACONARIE COCT			1. 00		
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.00	
2. 00	Program inpatient ancillary capital cost (see instructions)			0	2.00	
3. 00	Total inpatient program capital cost (line 1 plus line 2)				3. 00	
4.00	Capital cost payment factor (see instructions)			0	4. 00	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00	
			•	1. 00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00		
1.00	Program inpatient capital costs (see instructions)			0	1.00	
2.00	Program inpatient capital costs for extraordinary circumstan	nces (see instructions)		0	2. 00	
3.00	Net program inpatient capital costs (line 1 minus line 2)				3. 00	
4.00	Applicable exception percentage (see instructions)				4. 00	
5.00	Capital cost for comparison to payments (line 3 x line 4)				5. 00	
6.00	Percentage adjustment for extraordinary circumstances (see instructions)				6. 00 7. 00	
7. 00 8. 00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)				8.00	
9. 00					9.00	
10.00					10.00	
11. 00					11. 00	
12. 00						
13. 00						
14. 00						
15. 00	Current year allowable operating and capital payment (see in	structions)		0	15. 00	
16. 00						
	Current year exception offset amount (see instructions)			0	16. 00 17. 00	
			'	'		